Does Culture Matter? Investigating the Effect of Adherence to Asian Cultural Values on Perceived Difference between Eastern-style versus Western-style Asian Counselor

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CHAPTER I

INTRODUCTION

Over the past three decades, there is a growing consensus in the field of psychology, especially counseling psychology, that culture needs to be taken into consideration when working with the culturally diverse population, such as members of ethnic minority groups (e.g. Sue & Sue, 1977; Sue et al., 1982; Sue, Arredondo, & McDavis, 1992). Some scholars advocated for multicultural counseling competence (MCC) training for counselors, where ethnic minority individuals' culture is acknowledged and emphasized in the counseling process (e.g. Constantine & Ladany, 2000; Ponterotto & Casas, 1987; Sue, 1998; Sue, Arredondo, & McDavis, 1992). Various professional associations, such as the AACD (American Association for Counseling and Development; Sue, Arredondo, & McDavis, 1992) and APA (American Psychological Association, 1999), issued guidelines that empathized the central role of MCC. Counselors are urged to become culturally competent, in terms of fostering and enhancing multicultural counseling awareness, knowledge, and skills (Sue et al., 1982). It has been argued that providing psychotherapy without MCC could be unethical and even detrimental to ethnic minorities (Korman, 1974).

One ethnic minority group that has historically been pathologized and marginalized by mainstream psychology has been Asian Americans. Despite their greater needs for mental health services as a result of experiences with societal racism and discrimination (Kim, Ng, & Ahn, 2005), Asian Americans are reported to underutilize mental health services; when they do enter counseling services, they tend to terminate prematurely from treatment (U.S. Department of Health and Human Services, 2001). As such, there has been a growing need to better understand the Asian American community: its unique characteristics, within-group differences, as well as

effective mental health practices with this unique ethnic group (Kim & Omizo, 2010).

Recognizing the growing needs of mental health services amongst the Asian community, two camps of counseling researchers have made substantial contribution to improve current mental health practices with the Asian population. In North America, multicultural counseling researchers seem to have largely adopted an etic approach where models developed for mainstream White clients are adapted, one way or another, for use with Asian clients. Here the etic approach refers to "the search for universal laws of behavior" whereas the emic approach, which will be discussed later, refers to "the culture-specific approach" (Leong, 2002, p. 280). For example, some researchers have focused on identifying salient Asian cultural values and useful counseling strategies with the Asian American population, so as to increase therapy retention and maximize treatment effects, while the general framework of Western-style counseling remains the same (e.g. Kim & Atkinson, 2002; Kim, Atkinson, & Umemoto, 2001; Kim, Atkinson, & Yang, 1999; Kim et al., 2003).

Within the field of multicultural counseling research, a host of empirical studies have been conducted to identify and examine Asian culture values and its effects on counseling outcomes. For example, as one of the most comprehensive work on Asian cultural values, Kim, Atkinson, and Yang (1999) identified 14 value dimensions describing East Asian cultural values, including: (1) "Ability to resolve psychological problems" (i.e., One should be able to overcome their psychological distress; help-seeking behaviors are signs of weakness), (2) "Avoidance of family shame" (i.e., Family reputation and family honor are to be upheld at all times; one's failure reflects badly on one's extended family), (3) "Collectivism" (i.e., Interdependence over independence; placing group's interests over individual interests), (4) "Conformity to family and social norms and expectations" (i.e., One will observe social norms and fulfill familial

obligations), (5) “Deference to authority figures” (i.e., Authority figures are to be respected and never challenged), (6) “Educational and occupational achievements” (i.e., Success is defined by one’s educational and career achievements), (7) “Filial piety” (i.e., Allegiance to parents; the expectation that children should obey their parents’ wishes and take care of them in their old age), (8) “Importance of family” (i.e., Family obligation and family honor are the most important), (9) “Maintenance of interpersonal harmony” (i.e., Interpersonal harmony is maintained by avoiding conflicts and saving other people’s face), (10) “placing other’s needs ahead of one’s own” (i.e., One should be aware of others' needs and always try to accommodate them), (11) “Reciprocity” (i.e., Whenever a financial or personal favor is given, it should be returned with equal or greater value), (12) “Respect for elders and ancestors” (i.e., Children and juniors should treat elders and ancestors with absolute respect and deference), (13) “Self-control and restraint” (i.e., The ability to maintain calm and reserved despite strong emotions), and (14) “Self-effacement” (i.e., Minimization and depreciation of one’s achievement is valued; humbleness and modesty) (p. 575-579, Kim, Atkinson, & Umemoto, 2001).

Building on the knowledge of these Asian cultural values, Kim, Atkinson, and Umemoto (2001) proposed a theoretical model where they hypothesized the relationship between enculturation (e.g. maintaining of culture-of-origin values, behaviors, identity, and knowledge), acculturation (e.g. acquiring of U.S. cultural values, behaviors, identity, and knowledge), Asian American clients’ attitudes and behavior, counselor attitudes and behavior, as well as counseling outcome. They also proposed that: (1) “The counseling process will be impeded when the client’s cultural values conflict with cultural values inherent in counseling”, and (2) “the counseling process will be enhanced when the client’s cultural values are congruent with values inherent in counseling.”

Following this theoretical model, a series of empirical studies have been conducted, yielding inconsistent results regarding the effects of Asian cultural values on counseling outcomes. For example, Kim and Atkinson (2002) found a positive relationship between Asian American client's adherence to Asian cultural values and their rating of Asian American counselors' levels of empathy and credibility. Additionally, Kim, Li, and Liang (2002) found that when working with European American counselors, Asian American clients who had strong adherence to Asian cultural values rated their counselors more positively in terms of empathy and working alliance, as compared to those who had weak adherence to Asian cultural values. However, Kim et al. (2003) and Li & Kim (2004) found no relationships between Asian American clients' adherence to Asian cultural values and counseling outcomes with European American counselor.

In general, it seems that multicultural counseling researchers following this line of inquiry have been asking the same core question: How can we apply psychotherapy, a by-product of Western individualistic culture, to a population that more or less adheres to Eastern collectivistic culture?

Meanwhile, another group of counseling psychologists across the globe have been asking a similar question since the early 1980s (Hwang, 2009). Dissatisfied by the blind imposition of Western psychology practices and research paradigms on indigenous populations in non-Western worlds, indigenous counseling researchers in Asia advocated for an indigenized psychology in the Philippines, Japan, India, Taiwan, Korea, and Hong Kong, where a culturally meaningful psychology is build on local knowledge, wisdom, and resources (Hwang, 2009).

In recent years, the indigenous movement has primarily been carried out by Chinese scholars across several countries and regions in Asia (e.g., Chen, 2009; Hwang, 2005 & 2009;

Kuo, Hsu, & Lai, 2011; Kwan, 2009; Leung & Chen, 2009; Yeh, Hunter, Madan-Bahel, Chiang, & Arora, 2004; Zhang et al., 2002). In Taiwan, Hwang (2005) pointed out that psychology as a field was a product of academic colonialism, first dependent on the Japanese, later the Americans. Specifically, psychology was first introduced to Taiwan by Japanese scholars to "study the folk psychology of aborigines to serve the expansionist government's policies when Japan was aggressively seeking to colonize its neighbors to the south (p. 229)." After World War II, Taiwan became economically and politically dependent on the U.S., so did its science and technology (Hwang, 2005). In the field of psychology, knowledge developed in Europe and North America was imposed on the local people without much consideration of the Chinese psyche or the local context. This approach is called the "colonization of the social scientist" (p. 931) (Hwang, 2005; Gergen et al., 1996, as cited in Hwang, 2009) or "scientific racism" (p.932) (Sue and Sue, 1999, as cited in Hwang, 2009). Hwang and Wood (2007) pointed out the importance of understanding individuals' dysfunctions within their cultural context. They argued that Chinese people have been living in good health for thousands of years, and many aspects of the Chinese culture have served as a source of strength. The focus here is not to pathologize the culture, but to understand individuals within their cultural milieu.

As such, some indigenous counseling researchers called for a concerted effort to develop an indigenous psychology in Asia (Hwang and Wood, 2007). Ho (p. 94; Ho, 1998) defined indigenous psychology as "the study of human behavior and mental processes within a cultural context that relies on values, concepts, belief systems, methodologies, and other resources indigenous to the specific cultural groups under investigation." In other words, instead of outsourcing theories or practices to understand the behaviors and mental processes of local people, indigenous psychology relies primarily on internal knowledge and local resources. In

particular, indigenous therapies emphasizing interpersonal interdependency (Sue and Sue, 1999) and interconnectedness of mind, body, and spirit (Yeh, Hunter, Madan-Bahel, Chiang, & Arora, 2004) were developed. Example of indigenous therapies can be found in Reiki, charkra, qigong, pranic healing, yoga, breath work, and meditation (Yeh, Hunter, Madan-Bahel, Chiang, & Arora, 2004). Groups that reportedly utilize indigenous healing practices include Chinese Americans, Native Americans, and African Americans.

Given the similar question asked (i.e. "How can we apply psychotherapy, a by-product of Western individualistic culture, to a population that more or less adheres to Eastern collectivistic culture?), it is interesting to observe that little has been done to integrate multicultural counseling research and indigenous counseling research. In fact, counseling psychologists in both worlds seem to continue grappling with the idea of culture and its application to psychotherapy in their separate frontiers.

Does culture matter in psychotherapy? What is the impact of Asian cultural values on counseling outcomes (e.g. perceived counselor effectiveness), both with Asian Americans in the U.S., and with Asians in Asia? In the next section, a more in-depth review of multicultural counseling research and indigenous counseling research will be presented, both of which have been trying to answer this question from their own perspectives.

CHAPTER II

LITERATURE REVIEW

In their attempt to answer the question of whether and how culture matters in psychotherapy, two camps of counseling psychologists around the globe have made substantial contribution to the literature by building theoretical models and conducting empirical investigations. In the following section, a review of current literature on these two camps of studies will be presented: first multicultural counseling research in North America on Asian cultural values, then indigenous counseling research in various Asian countries/regions. This will be followed by a critique on issues encountered by each camp, as well as a proposal for a new way of conceptualizing culture in psychotherapy. Specifically, five key features that differentiate and operationalize Eastern vs. Western styles of counseling will be presented. Finally, rationale and hypotheses of the current study will be presented.

North America: Multicultural Counseling Research

U. S. Census Bureau (2010) defined "Asian" as "a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam" (p.2). According to the U.S. Census Bureau (2010), Asian Americans currently represent 4.8% of the total U.S. population, with over 14.7 million individuals. Between 2000 to 2010, Asian was the fastest growing racial group in the U.S. (U.S. Census Bureau, 2010). Asian immigration dates back to 1848, when the first group of Chinese immigrants arrived in San Francisco as gold mine workers; followed by Japanese arriving in 1868, Koreans in 1903, Filipinos in 1906, and Asian Indians in 1907 (Kim, Atkinson, & Yang, 1999). Given the widely reported underutilization and greater demands of mental health services

within the Asian American community (Kim & Atkinson, 2002), much of the current academic attention has been paid on investigating within-group cultural variables, such as acculturation and enculturation, client adherence to Asian cultural values, as well as their relationship to counseling outcomes (e.g. Kim & Atkinson, 2002; Kim, Atkinson, & Umemoto, 2001; Kim, Atkinson, & Yang, 1999; Kim et al., 2003).

Acculturation and enculturation

One important within-group cultural variable among Asian Americans is acculturation. Redfield et al. (1936) first defined acculturation as "those phenomena which result when groups of individuals sharing different cultures come into continuous first-hand contact, with subsequent changes in the original culture patterns of either or both groups" (p. 149, Kim, Ahn, and Lam, 2009). Afterwards, Graves (1967) defined psychological acculturation as changes in attitudes, values, and identity as a result of being in contact with other cultures. More recently, Berry (1980) dichotomized the concept of acculturation into two parts, namely, "contact and participation" as related to other's cultures and "cultural maintenance" as related to one's own culture (Kim, Ahn, & Lam, 2009). In a sense, acculturation is a process where individual learns and adapts to the mainstream dominant culture. Some scholars claimed that Asian Americans who are generations apart from their ancestors who first immigrated to the U.S. would be more acculturated than recent immigrants (Kim, Atkinson, & Umemoto, 2001).

Another closely related within-group variable is enculturation, which refers to the socialization process and maintenance of one's indigenous culture, with its values, norms, and beliefs (Herskovits, 1948). Kim, Ah, and Lam (2009) argued that for Asian Americans who are generations removed from their cultural roots, it is probably more accurate to use enculturation to grasp their socialization process, as "they may never have been fully enculturated into their

Asian ethnic group's cultural norms (p. 27)." As a result of these discussions, Kim and Abreu (2001) redefined enculturation as "the process of (re)learning and maintaining the norms of the indigenous culture" and acculturation as "the process of adapting to the norms of the dominant culture (p. 27, as cited in Kim, Ah, & Lam, 2009)."

While early scholars divided the process of acculturation into two dimensions, namely, value and behavior changes (Szapocznik et al., 1978), more recently researchers have proposed a new model which includes four dimensions of acculturation: behavior, values, knowledge, and identity (Kim & Abreu, 2001). In reviewing 33 instruments on acculturation, enculturation, or both, Kim and Abreu (2001) found that among about 85% of all these instruments, approximately 50% of the items assessed the behavioral dimension of acculturation and enculturation, such as choice of language, preference for friendship, choice of food, etc. The authors concluded that the behavioral dimension is an important aspect of acculturation and enculturation that has received the most academic attention, whereas other aspects of acculturation were more or less overlooked by academicians in this field.

Additionally, different categorization models have been proposed to understand the within-group differences in terms of Asian Americans' preference for acculturation and enculturation. For example, Sue and Sue (1971) proposed an early model where Asian Americans are categorized into three groups: the "traditional" type, "marginal" type, and "Asian American" type. Specifically, the "traditional" type includes those who identified strongly with their ethnic group culture while rejecting the dominant national culture; the "marginal" type refers to those who identify strongly with the dominant national culture, while rejecting their ethnic group culture; finally, the "Asian American" type refers to those who identify with both ethnic group culture and dominant national culture, or the "bicultural" orientation. Later, Berry

and colleagues (Berry, Kim, Power, Young, & Bajaki, 1989) proposed a new categorization model, where four basic statuses were identified: "integration," "assimilation," "separation," and "marginalization." Specifically, integration refers to those who identifies with both dominant group and the indigenous groups' cultures. In other words, individuals in this group demonstrate behaviors of high acculturation and enculturation. This group is also referred to as "bicultural" and was similar to Sue and Sue's "Asian American" group. In addition, the assimilation group refers to those who identify strongly with dominant culture while rejecting the indigenous culture. Separation refers to those who identify strongly with the indigenous culture while rejecting the dominant culture. Finally, marginalization refers to those who reject both dominant and indigenous cultures. According to both Sue and Sue (1971) and Berry et al., those who are in the bicultural group (i.e. high on both acculturation and enculturation) are expected to demonstrate positive psychological functioning, as opposed to all other groups (e.g. assimilation, separation, or marginalization).

In order to test this theoretical proposal (i.e. high acculturation and enculturation leads to positive psychological functioning) with empirical data, Kim and Omizo (2010) collected data in a sample of 112 Asian American high school students in Hawaii, where "positive psychological functioning" was operationalized using measures of general self-efficacy (i.e. beliefs about one's competence), cognitive flexibility (i.e. awareness of multiple options and choices and willingness to be flexible and adaptable), collective self-esteem (values placed on one's social group; encompassing four domains: membership, private, public, and importance-to-identity), and attitudes toward help-seeking behaviors. The results did not support the hypothesis that both high levels of acculturation and enculturation would lead to positive psychological functioning. However, results indicated that enculturation was positively associated with general self-

efficacy, cognitive flexibility, and collective self-esteem (membership, private and importance-to-identity). Additionally, acculturation was negatively associated with the importance-to-identity dimension of collective self-esteem. In other words, high levels of enculturation (e.g. adherence to one's culture-of-origin) were associated with positive psychological functioning.

Adherence to Asian cultural values

Adherence to Asian culture values, in particular, is a demonstration of behavioral and value enculturation. Hofstede (2001) defined values as "a broad tendency to prefer certain states of affairs over others" (p. 5). More specifically, cultural values were defined as "universalistic statements about what we think are desirable or attractive" (Smith & Bond, 1994, p. 52). As mentioned in the previous section, Kim et al (1999) identified 14 value dimensions describing East Asian cultural values using a three-stage research process: (a) a literature review on Asian cultural values (journal articles, books, book chapters, and dissertations on Asian cultural values), (b) a nationwide survey of Asian American psychologists (i.e. 28 Asian American psychologists members of division 45 of APA), and (c) three focus-groups with Asian American participants (i.e. doctoral Asian American students). The 14 value dimensions identified in their study included: (1) "Ability to resolve psychological problems," (2) "Avoidance of family shame," (3) "Collectivism," (4) "Conformity to family and social norms and expectations," (5) "Deference to authority figures," (6) "Educational and occupational achievements," (7) "Filial piety," (8) "Importance of family," (9) "Maintenance of interpersonal harmony," (10) "Placing other's needs ahead of one's own," (11) "Reciprocity," (12) "Respect for elders and ancestors," (13) "Self-control and restraint," and (14) "Self-effacement." (p. 575-579, Kim, Atkinson, & Umemoto, 2001). Kim et al (2001) also proposed two assumptions underlying their theoretical model of Asian cultural values: (1) "The counseling process will be impeded when the client's

cultural values conflict with cultural values inherent in counseling", and (2)"the counseling process will be enhanced when the client's cultural values are congruent with values inherent in counseling."

Based on these proposals, a series of empirical studies have been conducted with volunteer clients and trained counselors over the course of a session. For example, in a sample of 112 Asian American college students, Kim and Atkinson (2002) found a positive relationship between Asian American volunteer client's adherence to Asian cultural values and their rating of Asian American counselors' levels of empathy and credibility. In addition, they found a negative relationship between Asian American volunteer client's adherence to Asian cultural values and their rating of European American counselors' level of empathy. In general, they found that clients rated sessions with European American counselors as more positive than those with Asian American counselors. The authors emphasized that they utilized a "quasi-intervention analogue design" (i.e. using real clients with trained counselors, p. 5), which offered more realism and carried more generalizability than the usual "audiovisual analogue design" (p. 5).

On the contrary, Kim, Li, and Liang (2002) found within a sample of 78 Asian American college students that when working with a European American female counselor, student clients who had strong adherence to Asian cultural values rated their counselors more positively in terms of empathy and working alliance, as compared to those who had low adherence to Asian cultural values. In addition, clients in the "immediate resolution" condition rated their counselor more positively in terms of working alliance, as compared to those in the "insight attainment" condition. For clients with higher levels of adherence to Asian cultural values, those in the "expression of emotion" condition rated their counselor more positively in terms of cross-cultural competence, as compared to those in the "expression of cognition" condition.

Finally, Kim et al. (2003) and Li & Kim (2004) found no relationships between Asian American clients' adherence to Asian cultural values and counseling outcomes with European American counselor. In other words, empirical studies based on one-session volunteer client study have yielded inconsistent results.

Other cultural variables contributing to counseling outcomes, in addition to client's cultural value preference, have been taken into consideration. For example, Fischer, Jome, and Atkinson (1998) identified four common factors within different treatment methods, including client expectation, shared worldview between client and counselor, therapeutic alliance, as well as rituals or interventions. Fischer and colleagues argued that those with positive expectations for counseling outcome tend to benefit more from counseling, as compared those who have negative expectations. Similarly, they proposed that higher consistency between client and counselor worldview, better therapeutic alliance, as well as use of ritual and interventions would lead to more positive therapeutic outcomes. Fischer and colleagues (1998) argued that "The more the counseling participants share an understanding of each other's worlds, the easier it may be to form a therapeutic relationship (p. 534)."

Empirically, Li and Kim (2004) found that Asian American clients rated counselors more favorably when directive style was used, rather than indirective style. Kim, Ng, and Ahn (2005) found that when the client's worldview is matched with the counselor's worldview, client perceived stronger working alliance and counselor empathy. In addition, client's adherence to Asian cultural values was positively associated with working alliance. On the other hand, client's adherence to European American values was positively associated with working alliance and session depth. Finally, high expectation for session success and strong adherence to European American values predicted increased counselor empathy as perceived by the client. Kim, Ng, and

Ahn (2009) found that higher levels of client's perceived match on client-counselor belief about problem etiology were associated with higher levels of perceived counselor credibility, empathy, cross-cultural competence, client-counselor working alliance, session depth, as well as the likelihood of client recommending the counselor other clients. In addition, both higher levels of match on problem etiology and client expectation were associated with higher levels of working alliance. Additionally, Kim, Li, and Liang (2002) found that Asian American volunteer clients perceived a stronger working alliance with a European American female counselor when the focus of the session was on problem resolution rather than problem exploration. Finally, when European American female counselor engaged in self-disclosure of problem-solving strategies they have used in the past, Asian American clients rated these self-disclosure as helpful, especially when these disclosures are moderately intimate (Kim, et al., 2003).

In summary, empirically multicultural counseling research have identified various therapy factors, in addition to adherence to Asian cultural values that either hinder or enhance the outcome of psychotherapy with Asian American clients. These factors include counselor styles (direct vs. indirect), client expectation, shared worldview and belief about problem etiology between client and counselor, therapeutic alliance, session focus (problem resolution vs. problem exploration), counselor self-disclosure (present or absent of disclosure), as well as rituals or interventions. As far as specific therapy factors are concerned, multicultural counseling research have contributed a great deal of applicable knowledge to clinicians working with the Asian American population.

Eastern vs. Western communication styles

Another factor that was often mentioned in multicultural counseling research had to do with Asian communication styles. Hall (1976) identified two communications styles as related to

Eastern and Western cultures: high context communication and low context communication. As mentioned by Hall, in Eastern cultures, "most of the information is either in the physical context or internalized in the person, while very little is in the coded, explicit, transmitted part of the message (p. 79, Hall, 1976)"; whereas Western cultures tend to utilize low context communication, in which the "mass of the information is vested in the explicit code." (Hall, 1976). Gudykunst (2001) theorized that high context communication include "being indirect, inferring meaning, interpersonal sensitivity, using feelings to guide behavior, and using silence (p. 47, as cited in Park & Kim, 2008)." On the other hand, low context communication includes "being dramatic, dominant, animated, relaxed, attentive, open, friendly, contentious, and impression-leaving (p. 47)." According to Hall (1976), Asian cultures tend to value high context communication, while European cultures tend to value low context communication.

Park and Kim (2008) posited that the preference for high context communication within the Asian communities maybe understood through the emphasis of Confucianism on interpersonal harmony. They argued that the indirect communication styles are emphasized specifically due to its facilitative role in promoting interpersonal harmony. Traditional Asian culture discourages the open and expressive communication styles (Park & Kim, 2008). In Japanese culture, a highly verbal person is often taken lightly, while someone who is careful and circumspect in their speech is endowed with more trust than those who are considered "social" from a Western perspective (Nishida, 1996). Similarly, Chinese culture discourages self-disclosure in public, in fear of losing "face" (Park & Kim, 2008). Park and Kim (2008) conducted a principle components analysis suggesting that for both Asian American and European American college students, the contentious, dramatic, precise, and open communication styles loaded on the construct of low context communication; similarly,

interpersonal sensitivity and inferring meaning communication styles loaded on the construct of high context communication. In addition, the authors found that Asian American's use of a less open communication style was explained by higher adherence to emotional self-control and lower adherence to European American values. When sex and race were controlled, adherence to humility was negatively associated with contentious and dramatic communication styles, while positively associated with inferring meaning style; meanwhile, adherence to European American values was positively related to use of precise communication and inferring meaning communication styles, while collectivism was positively associated with interpersonal sensitivity communication style. Thus, communication styles (high vs. low context communication) seem to be influenced by value preferences (collectivistic vs. individualistic culture values).

In summary, multicultural researchers in North America seemed to have used an etic approach (Leong, 2002) where they have focused on identifying salient within-group cultural variables, such as acculturation and enculturation, adherence to Asian cultural values, and Eastern vs. Western communication/counseling styles, while the general framework of Western-style counseling remains the same. Across the globe, however, another group of counseling psychologists have followed an emic approach (Leong, 2002) to incorporate indigenous culture into counseling, namely, the indigenous counseling approach.

Asia: Indigenous Counseling

While multicultural counseling researchers advocated the multicultural counseling movement in North America, indigenous counselors across Asia advocated the incorporating of indigenous cultural values, knowledge, wisdom, and resources into the counseling process. Yeh and colleagues (2004) pointed out conflicts between values embraced by dominant Western approaches to counseling and psychotherapy (e.g. "individual relationships, verbal direct

communication, internal processes, and emotional expressiveness," p. 412) and cultural values held by individuals from interdependent cultures, including Asian cultures (e.g. "social connectedness, collectivistic relationships, and spiritual worldviews," p.412). As a result, individuals from interdependent or collectivistic cultures may be misunderstood by counselors as resistant, defensive, or superficial in therapy (Sue & Sue, 1999). Yeh and colleagues (2004) also highlighted potential mistake of viewing clients with less English proficiency as "deficient and abnormal (p. 412). In addition, Yeh and colleagues (2004) noted the different roles helpers/counselors are expected to take in Western traditions and interdependent/collectivistic cultures. While counselors working in the Westernized individualistic framework tended to assume a somewhat passive role in the belief that clients are capable of finding out solutions to their own problems, indigenous healers (e.g., Shamans) are expected to be hold more authority, power, and knowledge in the relationship and therefore expected to take a more active role.

In recent years, indigenous counseling researchers have made substantial contribution to the literature in terms of theory building and empirical studies. In reviewing the empirical literature on counseling and psychotherapy in non-Western world, three approaches emerged, namely, (1) the generalization approach; (2) the modification approach; and (3) the indigenization approach. While the generalization approach treated Western theories and practices of psychotherapy as generalizable to the Asian context, the modification approach took culture into consideration and made necessary modifications to fit the local context (Enriquez, 1993). Finally, the indigenization approach relied primarily on local sources, traditional healing practices, values, ideologies, and created therapeutic approaches entirely from within (Enriquez, 1993). The following paragraphs will examine empirical studies based on these three approaches.

The Generalization Approach

Some researchers challenged the common belief that Western therapeutic approaches should be fundamentally modified in order to meet the needs of Asian clients. For example, Molassiotis and colleagues (2002) argued that Western-based cognitive-behavioral group therapy could be used effectively with the Chinese population without fundamental modification. These authors conducted a randomized controlled trial on a sample of 46 Chinese patients with symptomatic HIV recruited in the outpatient clinic in a large hospital in Hong Kong. Three models of treatment were examined, including (1) cognitive-behavioral group therapy (CBT), (2) peer support/counseling group therapy (PSC), and (3) treatment as usual (i.e. no psychosocial intervention). Western-style, standard CBT procedures were adapted, including "cognitive restructuring, behavior change strategies, assertiveness skills, and relaxation training (p. 87)." Progressive muscle relaxation and homework assignments were also integrated to the CBT treatment, without any cultural modification. Results indicated that participants in the 12 weekly sessions CBT group increased significantly in both mood and quality of life, as compared to the other two groups. Those in the PSC group had worsened psychological adjustment immediately following the intervention, however this was improved dramatically at 6-month follow-up. The authors argued that psychological interventions could help improve mood symptoms and quality of life for Chinese patients with HIV, therefore should be integrated into client management in the future. As can be seen in this study, even though no cultural adaption was conducted in this study, participants still benefited from standard CBT procedures developed in the West, as compared to supportive treatment and no treatment.

Similar effects of Western-style psychoeducational support group was found to be effective in reducing Taiwanese dementia caregivers' levels of depression in a sample of 85

participants in Taipei (with a dropout rate of about 30%), although there was no significant effects found for reducing participants' subjective and objective burden of care (Chu et al., 2010). Specifically, the 12-week manualized support group included topics that addressed various important aspects of dementia caregiving, such as caregivers' feelings and emotions, patients' common behavioral patterns, financial issues, community resources, etc. Participants were randomly assigned to the experimental and control groups, and data on depression levels and burden of care were collected prior to the experiment, immediately after intervention, as well as one month after the intervention. The authors concluded that this Western-style support groups are effective methods to buffer the depressive symptoms amongst dementia patient caregivers in Taiwan.

Others have argued that Western-based process-oriented group therapy could be used effectively with the Asian population without fundamental modification. For example, Downs, Siang, and Chun (2009) reported a qualitative study on a cross-cultural, bilingual, process-focused group experience amongst a group of counselors, counselor educators, and trainees in Malaysia, facilitated by a counselor from the United States. While most counseling groups in Malaysia are content-driven (e.g., psychoeducational groups and CBT groups), autocratic (i.e. leader sets agendas; highly structured), these authors personally participated and reported a group counseling experience whereby within-group interaction and in-depth sharing was encouraged. The full-day group experience consisted of four components: (1) an introductory lecture and discussion; (2) an adventure based counseling exercise (i.e. "Birthday Lineup"); (3) a debriefing of the previous exercise; (4) and finally, a less structured group experience with a stated topic (i.e. work-related stress). Although members were quiet and generally followed the hierarchical communication pattern typical in most Chinese societies, an unexpected event

occurred at the mid-point of the last group seemed to have changed the whole dynamic. A group member started to use Chinese, her primary language, to talk about her work-related experience and that was echoed and responded by many members. Other members started talking in Chinese, and the authority of the group facilitator was lessened since he could only understood one fourth of what was going on in the group. The use of Chinese language seemed to have freed members from their dependence on the group leader, and the rest of the session seemed to flow naturally. The authors concluded that this provided experiential and qualitative evidence that process-focused group could actually benefit clients from other cultural backgrounds.

Additionally, process-focused groups such as gestalt psychodrama groups were reported to be effective with Taiwanese counselors-in-training from two Taiwanese universities (Coven, 2004). Despite the author's expectations that the counselor trainees would be less self-disclosing and less emotionally expressive, trainees demonstrated openness, emotional expressiveness, and readily took personal risks to engage in psychodrama. The author speculated on the reasons contributing to this discrepancy between expectation and reality, including counseling students' familiarity with western therapeutic approach as well as their strong desire to please the trainer and their professors.

Finally, some argued that Western-based family therapy (e.g. structural family therapy) could be used effectively with the Asian population without fundamental modification. Ma (2000) reported a qualitative research utilizing intensive case study (Sherman & Reid, 1994) to examine 17 Chinese families' treatment expectation, subjective experience, as well as treatment outcome in structural family therapy (Minuchin & Nichols, 1993) conducted in Hong Kong. Presenting issues in these nuclear and three-generation families include child/adolescent problems (e.g., school refusal, theft, anorexia nervosa, aggression), marital conflicts, and medical

problems (e.g., cancer). A total of six family therapists provided structural family therapy, focusing on helping the family increase the flexibility of the family system. Techniques such as enactment (i.e. encouraging clients to act out the family conflicts in the here-and-now) were used in 90-120 minute sessions on a bi-weekly basis for an average of 9.5 months.

Three months after the treatment, families were interviewed via open-ended questions tapping into the following areas: treatment expectations, treatment experience, as well as treatment outcome. Content analysis was utilized to analysis clients' responses. Results indicated that: (1) Treatment expectations were mostly psychoeducational/didactic, where the therapy was expected to be a "course" (i.e. an academic class) and the therapist a "teacher (p. 302, Ma, 2000);" (2) Treatment experience turned out to be process-oriented and experiential, where families were encouraged to talk amongst themselves and came up solutions themselves; (3) Treatment were described as successful by 15 of the 17 families participated. Areas of improvement identified by the participants included parent-child relationship, marital relationship, family cohesion, as well as relationship with school. Ma (2000) argued that family therapy does not need to meet Chinese client's expectations in order to be effective.

This study challenges the belief that Western therapeutic approach needs to be fundamentally modified to specific receiving culture in order to be effective. The author seemed to have gathered some self-report evidence for the effectiveness of non-culture-specific family therapy in their sample. However, their conclusion does not render culture-specific therapy more or less effective than non-culture-specific ones, due to the research methodology used (i.e. only one group, intensive case study). It would be better to compare culture-specific and non-culture-specific family therapies side by side in future controlled studies to see which one would result in more efficacy. Additionally, it is interesting to note that Ma (2000) considered culture-specific

family therapy to be "problem focused, individually based and psychoeducational in nature, rather than an approach which is family based, process oriented and experiential." Although these may very well be the expectations of Chinese families who had no prior exposure to therapy, the way indigenous therapy or "culture-specific" therapy is defined as "therapy that meets client's expectations" seems to be inconsistent with current literature on counseling indigenization. It would be important to explore what does "culture-specific" therapy means, and whether it is fundamentally the same concept as "indigenous therapy."

In summary, researchers in the generalization camp seem to propose that no fundamental modification is needed in applying Western-style counseling with the Asian population. Empirical studies examining this proposal were conducted in terms of CBT group therapy, psychoeducational support group, process-oriented experiential group, gestalt psychodrama group, as well as family therapy, with varying degrees of success. Although these studies demonstrated the utility of Western-based therapy approaches with the Asian population in various regions and countries in Asia, they were mostly developed and led by researchers from the Western world (e.g. Great Britain and the United States), thus introducing researcher bias to the validity of their conclusions; in addition, sample size in these studies tended to be small (e.g. 46 individual clients; 9 group members; and 17 families) and no control group was used except for the first study. It may be argued that some therapeutic factors in group and family therapies are universal and transferrable to different cultural settings (i.e. psychoeducation, empathy, working alliance, emotional support, etc.). However, it is hard to identify what these common therapeutic factors are and how they mediate positive results demonstrated in the above-mentioned studies. Lastly, since these studies were mostly imported and carried out by Western researchers, they served to maintain the *status quo* of the academic oppression mentioned before.

As counseling researchers grew increasingly aware of the limitations of the generalization approach, some started to experiment with a different approach where cultural context is incorporated into therapy, namely, the modification approach.

The Modification Approach

Some scholars proposed that Western therapeutic approaches, such as cognitive behavior therapy, can be effective with Chinese clients with proper modification (Hodges & Oei, 2007). Hodges and Oei studied the characteristics of CBT approaches as well as core Chinese values and proposed that these two are perfectly compatible with each other. Specifically, the authors argued that some of the defining features of CBT treatment, such as didactic teaching, utilization of homework, emphasis on homework and cognitive processes, present/future focus (Blagys & Hilsenroth, 2002, as cited in Hodges & Oei, 2007) are consistent with traditional Chinese culture, such as respect for authorities/experts, emphasis on didactic teaching and diligent work (i.e. homework), as well as present and future orientations. Finally, the authors proposed that although challenging and shaping the cognitive processing (i.e. irrational thoughts) does not sound compatible to Chinese values, client may benefit from challenging maladjusted thoughts and use therapy as a change agent for a new culture (Gao, 2001, as cited in Hodges & Oei, 2007).

Hwang, Wood, Lin, and Cheung (2006) integrated current theory, research, and clinical practice and proposed eighteen principles in adapting standard Western CBT treatment to the less acculturated Chinese American clients (e.g. immigrants, clients who grew up in Asia). These principles were developed to address three cores areas, namely, (1) general principles in CBT adaptation to Chinese clients, (2) strengthening the therapeutic alliance, and (3) understanding self and mental illness from a Chinese perspective. For example, under area (1), the author

proposed "Another way to adapt CBT to better meet the needs of Chinese American clientele is to engage in 'cultural bridging' of CBT concepts to Chinese cultural beliefs and traditions (p. 206). For instance, relaxation skills training could be bridged with indigenous practice such as meditation, *Tai Qi Quan* (a type of internal Chinese martial arts), and *Qi Gong* (a traditional meditative exercise which focuses on the harmony of breath, movement, and awareness; p. 296; Hwang, Wood, Lin, & Cheung, 2006). In short, these authors seemed to be promoting a modification approach to CBT with Chinese Americans, especially those who are less acculturated. A case study with a 12-year old Chinese American male was used towards the end of this article to illustrate the use of these proposals in real life case study and to demonstrate the effectiveness of applying culturally modified CBT skills with the Chinese population.

Integrating Empowerment Feminist Therapy (EFT, Worell and Remer, 2003), systems theory, and positive psychology (Seligman & Csikszentmihalyi, 2000), Tzou, Kim, and Waldheim (2012) designed a strength-based therapy approach, the Positive Feminist Therapy (PFT), specifically for Chinese women who are going through marital conflict or divorce. The goals of PFT are described as "to empower Chinese women to reclaim their sense of self on the path to achieving balance and self-efficacy, and to redirect their energy toward a synergy between themselves and society." Specifically, five phases of treatment include: (1) "establishing the therapeutic relationship and assisting clients in evaluating the current circumstance;" (2) "facilitating the understanding of the self within the broader social-cultural context;" (3) "empowering clients to uncover their strengths, reclaim their sense of self, and making personal decisions for their future," (4) "exploring feelings after the decision," and (5) "helping clients to develop and implement solutions to their problems with the ultimate goal of establishing a new life after divorce (p. 144)." The authors believed that this approach is context-sensitive and

cultural sensitive and will benefit Chinese and Chinese American women who are going through divorce or marital conflict. However, the authors recognized the limitations of the study and stated that this insight-oriented, contextual approach have limitations when used with clients who do not have the cognitive ability to engage in such way of thinking.

As can be seen from the above-mentioned studies, most research in the modification camp is limited to general principles and case studies, rather than randomized controlled clinical trials. Therefore, it is difficult to assess their efficacy based on existing literature, especially as compared to treatment models following the generalization approach or the indigenization approach. As more researchers in non-Western countries voiced their doubts about the generalization and modification approaches, a new generation of psychotherapy, namely, the indigenous psychotherapy, started to emerge in various scholarly communities in Asia.

The Indigenization Approach

Amongst the indigenization camp, some scholars endorsed a "blending" view, where indigenous forms of therapy (e.g. Taoism, Confucianism) are combined with empirically validated forms of Western psychotherapies (e.g. CBT) to create a new blend of therapy for the Chinese population. A good example of this is the creation and validation of the Chinese Taoism cognitive psychotherapy (CTCP) reported by Zhang et al. (2002). These authors argued that development of Chinese psychotherapy has to take into consideration the teachings of Confucianism and Taoism, as they are inseparable components of the Chinese culture and the Chinese psyche for thousands of years. Whereas Confucianism promotes "hierarchy, moral development, achievement, and social responsibility," Taoism embraces opposing values such as "conforming to natural laws, letting go of excessive control, and the flexible development of personality (p. 117, Zhang et al., 2002)." Zhang and colleagues (2002) argued that both

individual perception of stressors and individual coping styles are mediated by cultural values, therefore a combination of local values and Western therapeutic techniques may potentially lead to swift therapeutic change.

The authors conducted randomized control trials comparing three models of therapy on a sample of 143 urban Chinese patients diagnosed with GAD (Generalized Anxiety Disorder). The three models compared were (1) CTCP (Chinese Taoism cognitive psychotherapy), (2) benzodiazepines (BDZ), and (3) combined treatment of CTCP and BDZ. Specifically, those in the CTCP group went through a five-stage Taoism treatment, where patients learned about "the 32-character Taoist formula" didactically and kept a journal about their cognitive changes in the context of their stressors. The central values taught in this five-stage treatment were "maintain(ing) tranquility, act(ing) less, and follow(ing) the laws of nature (p.128, Zhang & et al., 2002)," which is deeply embedded in the Chinese culture, especially the Taoism teaching. Assessment of psychological adjustment, personality style, and coping style was carried out at intake, at one-month, as well as at six-month immediately post intervention. It was found that BDZ treatment reduced GAD symptoms at one-month, however the effects were not maintained at six-month follow-up. CTCP was related to slower treatment effect, however effects were maintained at a six-month follow-up. Finally, combined treatment of BDZ and CTCP led to both expedited and enduring treatment effect. In addition, CTCP treatment was associated with less type A behavior (i.e., high-strung), better coping strategies, and less neuroticism. The authors concluded that both CPCT and combined treatment of CPCT and BDZ are effective and enduring treatment than BDZ for urban Chinese patients with GAD. The authors cautioned against their findings stating that there were no long-term data to demonstrate if therapeutic effects of the CPCT and combined group would last after the treatment was terminated or when

the medication was ended for the combined group. However, they also pointed out the advantage of utilizing the standardized CPCT or combined approach in China given that they are easy to learn by junior clinicians as compared to the psychodynamic approach.

Following the same indigenization tradition, Ting and Ng (2012) proposed a tradition-sensitive approach to therapy among Chinese community in Malaysia (CIM), which combines the three major religions (i.e. Taoism, Buddhism, and Christianity) and Western psychotherapeutic techniques. In comparing the above-mentioned three religious traditions practiced within the Chinese community in Malaysia (CIM), the authors observed different explanations of psychopathology (i.e. suffering) and different ways to cope with these psychopathologies. For example, in terms of the etiology of psychopathology, The Taoism tradition believes that "suffering results from disruption in external force (*qi*) or spirit that controls mind and body;" Buddhist tradition believes that "Life is full of suffering due to the unnecessary attachment and desires for objects or to karma from the past life;" while the Christian tradition believes that "suffering is due to sinful human or to demonic influences. God may use suffering/mental illness as a means to teach patience, perseverance, and trust and to build character. (p. 944)" It is very clear that different religious traditions vary drastically in terms of ways to understand mental illnesses. The authors presented four case examples where tradition-sensitive approach to psychotherapy was used, for example, "use of religious rituals (prayer) and scriptures (p. 948)," "accepting the spiritual realm and religious practices in order to maintain filial piety (p. 949)," "use of religious resources in finding social identity (p. 951)," and "Buddhist and folklore practices in atonement (p. 952, Ting & Ng, 2012)."

Finally, Chen (2009) proposed a self-relation coordination counseling model for Taiwanese clients. The author differentiated Chinese interpersonal relationships into three broad

categories: (1) family relations; (2) family-like relations; and (2) nonfamily relations (Hwang, 1997-1998) and proposed that Chinese people behave quite differently depending on their assessment of the nature of the relations. In other words, Chinese people adopt different behavioral patterns based on the relational situation they are in. "Self-coordintaion" was defined as "a behavior that a person constantly and consciously coordinates with the task of achieving personal goals, fulfilling role obligations, and meeting related others's expectations in different situations in order to maintain harmonious social relationships." Counseling goals, therefore, are defined as "the restoration of psychosocial homeostasis by assisting in self-coordination and self-relation coordination (p.1000)." To achieve this goal, the authors proposed four counseling tasks: (1) increasing self-awareness and self-understanding; (2) coordination of the self with related others; (3) employing multiple conflict resolution strategies; and (4) managing unmet personal needs and distressed emotions with self-cultivation and self-content.

As can be seen from the aforementioned empirical studies in the indigenization approach, indigenous counseling researchers integrate cultural contexts, whether it was philosophy, theology, or indigenous healing practices, into their development of an indigenized counseling psychology. Both descriptive and qualitative methodologies were utilized in analyzing and reporting the results of these studies, and most of these indigenized psychotherapeutic approaches demonstrated efficacy with the Asian population. Although much work has been done in this field since the advent of psychology indigenization movement in the early 1980s, it is obvious that this field is still in its early stages of development.

Rationale and Hypotheses

Critique of multicultural counseling research

In reviewing the multicultural counseling research on Asian cultural values in North

America, it seems that its strength lies in its empirical tradition. In particular, from early on multicultural counseling researchers have relied primarily on quasi-experimental and experimental research methodologies (e.g. Kim & Atkinson, 2002; Kim, Atkinson, & Umemoto, 2001; Kim, Atkinson, & Yang, 1999; Kim et al., 2003) to empirically examine and validate their theories and hypotheses. In addition, researchers worked on both theory building (e.g. Constantine & Ladany, 2000; Ponterotto & Casas, 1987; Sue, 1998; Sue, Arredondo, & McDavis, 1992) and institutionalizing of their empirical results, such as the endorsement of MCC by AACD and APA (American Psychological Association, 1999; Sue, Arredondo, & McDavis, 1992).

However, one problem that seems to exist in the multicultural counseling research is difficulty in operationalizing the concept of "Asian culture" in the counseling process. In other words, how do clinicians know that they are in fact practicing culturally competent or culture-specific psychotherapy? When it comes to counseling and psychotherapy, culture can be treated in a superficial matter (e.g. asking a Chinese client how to say certain things in Chinese or details of a traditional Chinese holiday); others see culture as concrete techniques or specific indigenous practices (e.g. qigong or yoga) while ignoring the universal nature of culture and how it permeates the counseling process. Without constant learning and intensive self-introspection, clinicians can be practicing therapy with culturally diverse population without a sophisticated and nuanced understanding of the client culture. For novice psychologists, culture can be so elusive that the process of multicultural counseling becomes a hit-or-miss: there are no prescriptions, instructions, or manuals to follow. Is there a better way to understand and grasp the idea of "culture" in the counseling process? Does culture come across, despite the specific theoretical orientation clinicians subscribe to?

In addition, to date empirical studies within the field of multicultural counseling seemed to have focused on identifying individual factor that differentiates Eastern vs. Western styles of counseling (i.e. directive vs. indirective styles, self-disclosure or no self-disclosure, emotion-focus or cognition-focus, etc.), without much synthesizing or systematizing of key features differentiating Eastern vs. Western styles of counseling. Is there a way to identify and synthesize what the field has known, and makes a proposal for a systematic way of understanding Eastern-style communication in the therapy room?

Critique of indigenous counseling research

Comparatively speaking, the field of indigenous counseling research in Asia seems to be building its empirical infrastructure. In particular, three barriers can be identified in indigenous counseling research in Asia.

First and foremost, there seems to be no consistent way of operationalizing the concept of "indigenous counseling" across different regions and countries. In other words, "indigenous counseling" looks quite different in different parts of Asia, even countries with similar Confucian cultural background (e.g. China, Korea, and Malaysia). This may be due to the very nature of indigenous counseling, in that every approach is developed based on the unique sociopolitical, economic, historical, and cultural reality of that specific locality. For example, while some countries emphasize the use of religion in its application of indigenous counseling (Ting and Ng, 2012), others emphasize their philosophical and sociopolitical background (e.g. Zhang & et al., 2002). In other words, given the nature of indigenous counseling, there seems to be ample room for creativity and improvisation, therefore no unifying ways of operationalizing the concept of "indigenization" have been proposed. The disadvantage, given the lack of unified operationalization of the concept, is the difficulty it presents to empirical studies. As scholars

continue to define and operationalize "indigenous counseling" in their own ways based on resources and challenges faced by their community, it continues to render cross-national comparison difficult if not impossible.

Another common issue that is faced by indigenous counseling researchers in non-Western world has to do with individual diversity within a specific cultural group. That is, individuals who comprise a culture diverge vastly in terms of how much they adhere to their culture of origin. To date, there seems to be no differentiation of within-group variables, such as individuals' level of adherence to Asian cultural values. In other words, indigenous counseling researchers seem to assume that all individuals in Asia adhere to Asian cultural values in the same way. Given the process of globalization, urbanization, and modernization, is it fair to incorporate culture in the same way for all Asian individuals? Would indigenous counseling work better for some individuals, but not others, depending on how much they actually identify with their Asian roots? Are there any key features underlying Eastern vs. Western styles of counseling, so that these can be identified and empirically examined for its validity with culturally diverse clients? These questions remain to be answered.

A final issue faced by indigenous counseling researchers seems to be the lack of empirical support for their theories and proposals. As can be seen from the above-mentioned review of indigenous counseling research in non-Western world, there exist lots of theoretical models, but not so many empirical studies, especially randomized controlled studies. Most studies on indigenous counseling utilized a qualitative approach (e.g. intensive case study), leading to skepticism as to its empirical validity. In addition, there has been mixed results regarding the effects of indigenous and Western-style counseling on Asian individuals.

Rationale and hypotheses

Given the above-mentioned issues faced by multicultural counseling researchers and indigenous counseling researchers in both worlds, perhaps what they can do is to learn from each other. Specifically, multicultural counseling researchers may learn from indigenous counseling researchers a broader understanding of culture and an international perspective, while the latter may learn from the former their empirical tradition. My study, therefore, could be seen as an integration of the above-mentioned two traditions, where I adopted a synthesized and nuanced approach to the concept of "culture" in empirically studying counseling outcomes with the Asian American population.

Recall that multicultural counseling research in the United States tended to focus on identifying individual therapy factors that differentiated Eastern vs. Western styles of counseling (i.e. directive vs. indirective styles, self-disclosure or no self-disclosure, emotion-focus or cognition-focus, etc.) without much synthesizing or systematizing. Additionally, in previous outcome studies (e.g. Kim & Atkinson, 2002; Kim, Atkinson, & Umemoto, 2001; Kim, Atkinson, & Yang, 1999; Kim et al., 2003), it was unclear whether the effect of client adherence to Asian cultural values on perceived counselor effectiveness was a function of counselor ethnicity (i.e. Asian American counselor vs. European American counselor) or counseling style (i.e. Asian-styled counseling vs. Western-styled counseling). Finally, results from these outcome studies were inconsistent in terms of the effect of client adherence to Asian cultural values on perceived counselor effectiveness.

Can we safely assume that all Asian counselors practice counseling in a way that is consistent with Asian cultural values? What if the difference lies in counseling style, rather than counselor ethnicity? Can we provide a synthesized approach to empirically operationalize Asian-

style vs. Western-style counseling? These questions remain to be answered.

In my study, I assessed the effect of client adherence to Asian cultural values on perceived counselor effectiveness based on counseling style (i.e. Asian-style counseling vs. Western-style counseling) rather than counselor ethnicity (i.e. Asian American counselor vs. European American counselor). In order to operationalize the different counseling styles, I identified five sets of contrasting features from the literature (e.g. Yeh et al., 2004; Zhang et al., 2002; Ting & Ng, 2012; and Chen, 2009) that differentiated Asian-style vs. Western-style counseling. These contrasting features included: (1) counselor roles (facilitator vs. expert); (2) individualistic vs. collectivistic approaches (i.e. focus on individual vs. focus on context/family dynamics); (3) counselor preferred mode of expression (verbal vs. non-verbal; or low context vs. high context communication); (4) avoidance of direct guidance/suggestion vs. direct guidance/suggestion; (5) avoidance of counselor self-disclosure vs. counselor self-disclosure of strategies used in the past. In this study, the "Asian-style counseling" was characterized by the expert role of the counselor, a collectivistic approach to counseling, use of non-verbal expression, utilization of direct guidance/suggestion, and self-disclosure of strategies used in the past. Alternatively, the "Western-style counseling" was characterized by the facilitator role of the counselor, an individual approach to counseling, encouragement of verbal expression, avoidance of direct guidance/suggestion, and avoidance of self-disclosure.

Recall that Kim, Atkinson, and Umemoto (2001) made two theoretical proposals stating that: (1) "The counseling process will be impeded when the client's cultural values conflict with cultural values inherent in counseling", and (2) "the counseling process will be enhanced when the client's cultural values are congruent with values inherent in counseling." Based on these proposals, as well as previous research on Asian cultural values and counseling outcomes (e.g.,

Kim & Atkinson, 2002; Kim, Atkinson, & Umemoto, 2001; Kim, Atkinson, & Yang, 1999; Kim et al., 2003), it was my hypothesis that Asian American participants' adherence to Asian cultural values would predict perceived counselor effectiveness based on counseling styles. In addition, given the nature of the proposed study whereby two styles of counseling (i.e. Asian-style counseling and Western-style counseling) will be compared side by side, we are also interested to see if participants' adherence to Asian culture values are predictive of the difference between their ratings of the two counseling styles. In other words, not only are we interested in investigating the relationship between participants' adherence to Asian culture values and their rating of Asian and Western-style counseling respectively, we are also interested in if their levels of adherence to heritage culture impact their comparative rating of the two styles of counseling. We believe this comparative rating taps into participants' sensitivity to style differences as well as their style preferences, which none of the previous Kim et al. studies had a chance to evaluate given their participants were only exposed to one style (i.e. either Asian American or European American counselor). Our study, on the contrary, exposes each participant to both Asian-style and Western-style counseling, thus providing the previous opportunity for us to empirically examine participants' style preferences and sensitivity to style differences. Specifically, two hypotheses were proposed:

Hypothesis 1: Adherence to Asian cultural values will be significantly predictive of perceived counselor effectiveness based on counseling styles. 1 (a) Stronger adherence to Asian cultural values will predict higher rating of Asian-style counseling; 1 (b) weaker adherence to Asian cultural values will predict higher rating of Western-style counseling.

Hypothesis 2: Adherence to Asian cultural values will be significantly predictive of perceived difference between Asian-style counseling and Western-style counseling. Stronger

adherence to Asian cultural values will predict larger difference between ratings for Asian-style counseling and Western-style counseling. Table 1 illustrates these hypotheses (see next page).

The following chapter (Chapter Three) will describe the methodology of this study, including the research design, participants, measures, and procedure. Chapter Four will present the results. The study's findings, limitations, and implications for mental health professionals will be discussed in Chapter Five.

Table 1

Research Hypotheses

Hypothesis	Independent Variable (IV)	Dependent Variables (DVs)	Notes
1	Adherence to Asian cultural values (Measured by AAVS-M)	Perceived counselor effectiveness (Measured by CERS-Asian and CERS-Western)	(a) Higher AAVS-M will predict higher CERS-Asian; (b) Lower AAVS-M will predict higher CERS-Western
2	Adherence to Asian cultural values (Measured by AAVS-M)	Perceived difference between Asian-style counseling and Western-style counseling (Measured by CERS-Difference)	Higher AAVS-M will predict larger CERS-Difference

Note. AAVS-M = Asian American Values Scale-Multidimensional; CERS-Asian = Counselor Effectiveness Rating Scale-Asian Style; CERS-Western = Counselor Effectiveness Rating Scale-Western Style; CERS-Difference = Counselor Effectiveness Rating Scale-Difference Score between Asian and Western Styles (i.e. Asian-styled rating minus Western-styled rating).

CHAPTER III

METHOD

Research Design

Research Design

A within-subject design was used in this study where all participants were exposed to two visual-audio vignettes (Asian-style counseling vignette vs. Western-style counseling vignette) and a series of scales.

Participants

Participants were 244 adult Asian and Asian Americans (including East Asian, South Asian, and Southeast Asian) currently residing in the United States. In the final analyses, we only included East Asian participants (N = 195), primarily because the cultural difference between East Asian and other Asian groups; additionally, the AAVS-M was designed essentially for East Asian participants with items stipulating East Asian cultural values. An a priori power analysis calculation yielded a sample size of 70 to achieve a power equal to .80 with a medium effect size (Pearson r, r = .30; Cohen, 1988) and an alpha level equal to .05. Thus, the number of participants accommodates the planned statistical analysis. Participants were recruited via the Internet through email invitations sent to various Asian and Asian American online forums, social-networking communities, and academic institutions. The study was voluntary and anonymous and could be done in one 20-minute session. Once participants logged on to the study website, they were asked to give informed consent to participate in the study as well as filling out their demographic information; afterwards, they were asked to watch two 5-minute pre-recorded counseling sessions and fill out several scales asking their perceptions of the

session as well as their adherence to Asian cultural values. Upon completion of the study, participants entered into a raffle to win an iPad mini (worth $299) if they wished to.

Approximately half of those who attempted the online study were omitted before we obtained the sample of 244 Asian and Asian American participants. A new dummy-coded variable named "group" was created in the data file, where participants were categorized into either the "complete" group (dummy code = 1) or the "incomplete" group (dummy code = 0). Because no systematic differences for missing responses were found among the measures (see "handling missing data" in Chapter IX: Results), they were judged to be missing at random and available item analysis (AIA, see Parent, 2013) was used to account for the missing responses in cases in which at least 70% of the scale item responses were obtained and available for analysis for a particular participant. In particular, participants were manually categorized into the "incomplete" group if they left out a whole scale, completed less than 70% of all items within one scale, or if they met our "exclusion criteria" (i.e. identifying other than Asian or Asian American, over the age of 18, or residing outside of the United States). We created the 70% cut-off percentage for the purpose of this study so we could easily identify which scales are "complete" and which are "incomplete."

Demographic characteristics for our East Asian sample are presented in Table 2. Ages of participants ranged from 18 to 51 years old, with a mean of 25.86 and a standard deviation of 5.30. Years resided in the United States ranged from less than a year to 51 years, with a mean of 13.73 and a standard deviation of 10.56. The sample was predominantly female, with 144 female participants (73.8%) and 49 male participants (25.1%). In terms of ethnicity, more than two thirds of the participants identified as being "Chinese" (69.2%), followed by "Korean" (18.5%), "Japanese" (5.6%), "Taiwanese" (5.6%), and "Other (mixed race within East Asian heritage)"

(1%). In terms of immigration status, about half of the sample identified as being a "U.S. Citizen" (49.7%), followed by "Non-resident Alien" (39.7%), and "Permanent Resident" (11.3%). A total of 69.2% of the sample were categorized as "Not born in the USA," while 30.3% categorized as "Born in the USA."

Table 2
Summary of Self-reported Demographic Information (N = 195)

Variable	Mean	SD	Range	Skewness	Kurtosis
Age	25.86	5.30	18-51	1.26	2.52
Years in the U.S.	13.73	10.56	0-51	.53	-1.51
Gender	Frequency			Percent	
Male	49			25.1	
Female	144			73.8	
Race	Frequency			Percent	
Asian	195			100	
Ethnicity	Frequency			Percent	
Chinese	135			69.2	
Korean	36			18.5	
Japanese	11			5.6	
Taiwanese	11			5.6	
Other	2			1	
Immigration Status	Frequency			Percent	
Non-resident Alien	74			39.7	
Permanent Resident	22			11.3	
U.S. Citizen	97			49.7	
East Asian or Not	Frequency			Percent	
East Asian	195			100	
Non-East Asian	0			0	
Born in the USA	Frequency			Percent	
Born in the USA	59			30.3	
Not born in the USA	135			69.2	

Measures

Demographics

Participants were asked to identify their age, gender, race, ethnicity, years/months resided in the U.S., and immigration status.

The Asian American Values Scale-Multidimensional (AAVS-M)

The AAVS-M (Kim, Li, & Ng, 2005) was used to assess participants' adherence to Asian cultural values. The AAVS-M is a measure of Asian American cultural values, such as collectivism, conformity to norms, emotional self-control, family recognition through achievement, and humility. It is derived from its previous version, the Asian Values Scale (AVS; Kim, Atkinson, & Yang, 1999), which yielded low coefficient alphas. The 42-item AAVS-M was developed by eliciting from a 180-item pool from a national sample of Asian American psychologists. A principal component analysis resulted in a 42-item, 5-factor solution, which was then supported by a separate study utilizing confirmatory factor analysis. Sample items of AAVS-M include "One should recognize and adhere to the social expectations, norms and practices" and "One's academic and occupational reputation reflects the family's reputation." The entire scale consists of 42 statements on a 7-point Likert-type scale, ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). Based on a sample of 163 Asian American college students, the AAVS-M was reported to have Cronbach's alphas ranging from .79 to .90 across its five subscales, with a score of .89 for the total scale. Test-retest reliability scores over a 2-week period, utilizing a different sample of 38 Asian American college students, ranged from .73 to .92 across its five subscales, with a score of .92 for the total scale score. Concurrent validity was supported by positive correlations between the AAVS-M scores and the AVS scores, as well as negative correlations between the AAVS-M scores and the scores of the Attitudes Toward

Seeking Professional Psychological Help Scale – Short Form (ATSPPHS-SF; Fischer & Farina, 1995). Finally, discriminant validity was supported by a low correlation between the AAVS-M total and subscale scores and the Rosenberg Self-Esteem Scale (RSES; Rosenberg, 1965).

The Counselor Effectiveness Rating Scale (CERS)

As a frequently used outcome measure for studies on Asian culture values, the CERS (Atkinson & Carskaddon, 1975) is a global measure of perceived counselor credibility based on four dimensions (i.e., expertness, attractiveness, trustworthiness, and utility). The CERS consists of 10 items rated on a 7-point scale, ranging from 1 (*bad*) to 7 (*good*). In a sample that consists of 32 White college students, 32 mental health clinic patients, and 32 federal correction facility inmates, the internal consistency of the CERS was reported as .90 (Atkinson and Wampold, 1982) for the CERS scores. With Asian American sample, the CERS was found to have coefficient alphas of .91(Kim and Atkinson (2002), .87 (Kim et al. , 2002), and .91 (Li & Kim, 2004) respectively. Concurrent validity was reported by Atkinson and Wampold (1982) with a correlation coefficient of .80 between the CERS and the Counselor Rating Form (CRF; Barak & LaCrosse, 1975). For the current study, the average score of the CERS was used in data analysis, ranging from 1 (*bad*) to 7 (*good*). Counselor effectiveness of each videotaped vignette was assessed by the CERS in this study.

Manipulation Check Questionnaire

A manipulation check was in place to assess if participants indeed experienced the two conditions differently based on the five criteria we used to operationalize Asian vs. Western styles (i.e. counselor roles; individual vs. collectivistic approaches; counselor preferred mode of expression; presence vs. absence of direct guidance/suggestion; and presence vs. absence of counselor self-disclosure). In particular, participants were asked to rate the two conditions based

on these five criteria on a 7-point Likert-type scale ranging from 1 (100% *individualistic*) to 7 (100% *collectivistic*), which yielded two rating scores (Manipulation-Asian and Manipulation-Western). A median split of the 7-point Likert-type scale was utilized, where a score of 4 or higher was considered a "favorable" rating for each feature identified in the vignette. For example, if a participant gave a rating of 4 or higher on the item of "individual vs. collectivistic approaches," we believe that the session was more "collectivistic" than "individualistic" to that particular participant. Putting together all five sets of features identified above, we wanted to assess if participants indeed experienced the two conditions differently based on the five criteria we used to operationalize Asian vs. Western styles.

Procedure

Development of the video vignette

As mentioned in Chapter II, the present study intended to utilize an audiovisual analogue design to evaluate whether participants' adherence to Asian cultural values predicts their perceived counselor effectiveness of an Asian American counselor, based on counseling styles (Asian vs. Western style). Five sets of contrasting features were identified from the literature that differentiated Asian-style vs. Western-style counseling, including: (1) counselor roles (facilitator vs. expert); (2) individualistic vs. collectivistic approaches (i.e. focus on individual vs. focus on context/family dynamics); (3) counselor preferred mode of expression (verbal vs. non-verbal; or low context vs. high context communication); (4) avoidance of direct guidance/suggestion vs. direct guidance/suggestion; (5) avoidance of counselor self-disclosure vs. counselor self-disclosure of strategies used in the past. Based on the identified features of each condition (Asian-style vs. Western-style), two 5-minute scripted counseling vignettes were developed employing the same dyad of Asian research assistants in the English language. One research

assistant role-played the counselor who followed a three-stage session process (identification of the problem, exploration of underlying issues or brainstorming possible solutions, and summary of treatment process), while the other research assistant role-played the client who followed the counselor's lead in session. Both research assistants were aware of the condition they represented, and did their best to demonstrate the effectiveness of each condition. Within each condition, a 5-minute long written script was developed by this author and was followed closely by researcher assistants who acted as the counselor and client. The idea was that the written scripts for the two vignettes matched as closely as possible except for the five dimensions under investigation. In order to further illustrate the two different conditions (Asian style vs. Western style), a brief description is provided below for each condition.

In the Asian-style condition, the counselor started by introducing herself and asking client to state briefly his reason for seeking services. Client talked about his recent struggles with career concerns (e.g. trying to choose between pre-med or art majors as a first generation Asian American; worrying about career choices and future prospects). Stage 1, identification of problem: the counselor asked client to identify one problem he would like to focus on for the session; stage 2, exploration of presenting issues: counselor and client processed possible solutions for the presenting problem. Throughout the session, counselor maintained an expert role by providing direct guidance/suggestion and engaging in self-disclosure of strategies used in the past with similar problems. Meanwhile, the counselor encouraged client to express how he felt in non-verbal approaches (i.e. mirroring of affect and postures). Counselor also utilized a collectivistic approach where family dynamics and family needs were addressed, in addition to individual needs; stage 3, summary of treatment process: counselor summarized what happened in the session and ended with encouragement for client's willingness to work on his issues (see

Appendix 1 for scripts of the video session).

In the Western-style condition, client came in with the same issue and was introduced to therapy in the same fashion. Stage 1 and Stage 3 in this condition looked exactly the same as those in the previous condition (Asian-style), however stage 2 looked different. Specifically, at stage 2, instead of processing solutions, client was asked to explore underlying issues of his presenting problem; meanwhile, counselor encouraged client to verbally express his feelings (e.g. how do you *feel* about this) and thoughts (e.g. how do you *think* about this). Throughout the session, counselor maintained a facilitator role by refraining from giving solutions/suggestion/self-disclosure; instead counselor encouraged client to explore his own issues and come up with his own understandings. Additionally, session focused strictly on client's individual needs, while processing of family needs were discouraged. In other words, the written script for the second vignette (Western-style condition) was exactly the same as the first vignette (Asian-style condition) for stage 1 and 3, with variations on stage 2 (see Appendix 1 for scripts of the video session).

Videotape judges

A panel of experts consisting of 1 practicing psychologist, 1 psychology professor, and 3 graduate students in counseling/clinical psychology programs served as videotape judges for this study. Judges were asked to identify their age, gender, race, ethnicity, highest degree completed, years/months resided in the U.S., immigration status, and previous counseling experience. The judges were asked to disclose their biases before their participation of the study, and they were blind to the experimental conditions. No prior training was provided as judges were asked to evaluate the videos based on their own clinical training and expertise.

In order to judge the validity of the two experimental conditions, these video-tape judges reviewed each 5-minute vignette individually and rated their perceptions of the video on the five sets of features similar to those presented in the Manipulation Check, including (1) counselor roles (facilitator vs. expert); (2) individual vs. collectivistic approaches (i.e. focus on individual vs. focus on context/family dynamics); (3) counselor preferred mode of expression (verbal vs. non-verbal; or low context vs. high context communication); (4) avoidance of direct guidance/suggestion vs. direct guidance/suggestion; (5) avoidance of counselor self-disclosure vs. counselor self-disclosure of strategies used in the past. A 7-point Likert-type scale was developed, ranging from 1 (100% *individualistic*) to 7 (100% *collectivistic*), and scores from this scale was collected to assess the validity of the two separate conditions. A median split of the 7-point Likert-type scale was utilized, where a score of 4 or higher was considered a "favorable" rating for each feature identified in the vignette. For example, on the item of "individual vs. collectivistic approaches," a score of 4 or higher was considered a "favorable" rating for the "collectivistic approach."

Ratings of both vignettes come out favorably for all five features identified, with 5 judges giving a mean score of 5.15 for features of the Asian-style counseling and a mean score of 2.2 for features of Western-style counseling. In other words, our judges considered our vignettes as valid in demonstrating "Asian style" and "Western style" on the basis of the five identified features. In order to enhance the visual and sound quality of the final videos, we re-recorded both vignettes following the same script verbatim. This final version of videotaped vignettes was launched online.

Data collection sessions

Once participants clicked the study link on the email/online recruitment announcement, they were directed to the online study. Once participants logged on to the study website, they were asked to complete the informed consent and demographics. Afterwards, they were asked to watch two 5-minute vignettes of pre-recorded counseling sessions. After viewing these vignettes, they were asked to rate counselors' effectiveness and assess their own adherence to Asian cultural values with the two above-mentioned measures (i.e. CERS and AAVS-M). At the end of the survey, they were asked to complete a manipulation check (similar to what the video tape judges completed) and were asked if they wish to enter into a raffle to win a prize. Participants were encouraged to ask any questions they had via email. Participation was completely voluntary and anonymous, and they could withdraw participation at any time.

CHAPTER IV

RESULTS

Preliminary Analyses

Handing missing data

As mentioned in the previous section, approximately half of those who attempted the online study were omitted due to incompletion before we obtained the final "clean" sample of 244 participants. Within this clean sample, an "East Asian" sample was selected for our analyses. Given our research design where participants were mostly recruited online with little incentive to complete the study except for entering into a raffle, we were not entirely surprised that half of our participants dropped out after a quick glance at the online survey. In order to assess whether those who dropped out prematurely differed from those who completed the study, participants were manually categorized into the "data complete" group and "data missing" group by creating a dummy-coded variable labeled "group." Those who had incomplete responses (i.e. leaving out a whole scale or completed less than 70% of all items within each scale) or met exclusion criteria (e.g. identifying other than Asian or Asian American or residing outside of the United States) were put into the "data missing" group by manually assigning a value of 0 for the "group" variable, while those who had complete responses were put into the "data complete" group by manually assigning a value of 1 for the "group" variable.

A series of χ^2 analysis were used to assess if those who completed the study and those who did not complete the study differed in terms of gender, race, ethnicity, and immigration status. Results indicated that there was no significant relationship between the type of group and gender ($\chi^2 = .26$, $df = 1$, $p = .61$), group by race ($\chi^2 = 8.09$, $df = 4$, $p = .09$), group by ethnicity ($\chi^2 = 2.48$, $df = 4$, $p = .65$), and group by immigration status ($\chi^2 = 2.27$, $df = 2$, $p = .32$). In other

words, those who completed the study and those who did not complete the study did not differ in terms of gender, race, ethnicity, or immigration status.

Additionally, a series of independent samples t-test were used to test if those who completed the study and those who did not complete the study differed in terms of age, years resided in the U.S., adherence to Asian cultural values (i.e. AAVS-M score), perceived counselor effectiveness of Asian-style counseling (i.e. CERS-Asian score), perceived counselor effectiveness of Western-style counseling (i.e. CERS-Western score), and perceived difference between Asian-style and Western-style counseling (i.e. CERS-difference score). To prevent type I error, Bonferroni correction was used, where the significance level for these analyses was adjusted to .05/6=.008. The results indicated that there was no significant difference between the two groups in terms of age (t = -1.50, df = 471, p = .14), years resided in the U.S. (t = .24, df = 471, p = .81), AAVS-M score (t = 2.05, df = 256, p = .04), CERS-Asian score (t = -1.66, df = 276, p = .10), CERS-Western score (t = -2.01, df = 275, p = .05), and CERS-difference score (t = .03, df = 275, p = .98).

In summary, those who completed the study and those who did not complete the study did not differ in terms of age, years resided in the U.S., adherence to Asian cultural values, perceived counselor effectiveness of Asian-style counseling, perceived counselor effectiveness of Western-style counseling, or perceived difference between Asian-style and Western-style counseling. In other words, no systematic differences for missing responses were found among the measures, and responses were judged to be missing at random. The final "clean" sample of 244 participants who completed the study was used in the following analyses.

Descriptive statistics

After confirming that our "clean" data set was unbiased, we examined the descriptive statistics of our East Asian sample to get a sense of the demographic character of our sample. Descriptive statistics, including alphas, means, standard deviations, and ranges of actual scores—for all independent and dependent subscales are presented in Table 3. Mean scores were used for all our measures, including Counselor Effectiveness Rating Scale (CERS, Atkinson & Carskaddon, 1975) and Asian American Values Scale – Multidimensional (AAVS-M, Kim, Li, & Ng, 2005) following Kim et al.'s previous studies on Asian cultural values (e.g. Kim & Atkinson, 2002; Kim, Atkinson, & Umemoto, 2001; Kim, Atkinson, & Yang, 1999; Kim et al., 2003).

Table 3
Descriptive Statistics of Subscales (N = 195)

Variable	α	M	SD	Range (Actual)	Skewness	Kurtosis
Demographic Questionnaire						
Age	-	25.86	5.30	18-51	1.26	2.52
Years resided in the U.S.	-	13.73	10.56	0-51	.53	-1.51
Counselor Effectiveness Rating Scale (CERS, Atkinson & Carskaddon, 1975)						
CERS-Asian	.96	4.42	1.27	1.5-7	.14	-.76
CERS-Western	.97	4.50	1.26	1-7	-.05	-.50
CERS-Difference	-	-.08	1.16	-3.93-6	1.03	5.11
Asian American Values Scale – Multidimensional (AAVS-M, Kim, Li, & Ng, 2005)						
AAVS-M	.90	3.93	.64	1.71-5.43	-.37	.54
AAVS-Collectivism	.81	3.88	.95	1-6.43	-.20	.75
AAVS-Conformity	.72	3.97	.91	1.43-6.14	-.32	-.12
AAVS-Emotional Control	.81	3.33	.95	1-6	.18	-.27
AAVS-Achievement	.91	4.33	1.05	1-6.93	-.44	.50
AAVS-Humility	.78	3.84	.99	1.83-7	.54	.47
Manipulation Check Questionnaire						
Manipulation-Asian	-	4.16	.95	1-7	-.45	.42
Manipulation-Western	-	2.91	.88	1-5.8	.54	.89

Note. High scores on all measures indicate higher amounts of that variable. For all variables, the higher number represents a greater amount of that construct. CERS-Asian = Counselor Effectiveness Rating Scale-Asian Style; CERS-Western = Counselor Effectiveness Rating Scale-Western Style; CERS-Difference = Counselor Effectiveness Rating Scale-Difference Score between Asian and Western Styles (i.e. Asian-styled rating minus Western-styled rating); AAVS-M = Asian American Values Scale-Multidimensional; AAVS-Collectivism = Asian American Values Scale- Collectivism subscale; AAVS- Conformity = Asian American Values Scale- Conformity subscale; AAVS- Emotional Control = Asian American Values Scale- Emotional Control; AAVS- Achievement = Asian American Values Scale- Achievement subscale; AAVS- Humility = Asian American Values Scale- Humility subscale; Manipulation-Asian = Manipulation Check Questionnaire- Asian Style; Manipulation-Western = Manipulation Check Questionnaire- Western Style.

As can be seen from Table 3, coefficient alphas demonstrated adequate levels of internal consistency for both Counselor Effectiveness Rating Scale (CERS, Atkinson & Carskaddon, 1975) and Asian American Values Scale – Multidimensional (AAVS-M, Kim, Li, & Ng, 2005), with alphas ranging from .72 to .97. Therefore, it is safe to say that our two main measures, the CERS and AAVS-M, had good internal consistency. We did not run alphas for the Manipulation Check Questionnaire because it assessed five separate sets of criteria (e.g. counselor role and counselor approach) rather than a single central construct (see p. 40 for a detailed explanation of the Manipulation Check Questionnaire).

In terms of normality, all variables, except for age (kurtosis = 2.52) and the CERS-Difference (kurtosis = 4.91), had skewness and kurtosis within the range of -2 to 2 (George & Mallery, 2010), indicating that most variables of interest were normally distributed. Further investigation of age and the CERS-Difference scores through visually inspecting histograms revealed that even though the score distributions were not normal, they were close to normal.

In terms of means and standard deviations, this sample is quite young, with a mean age of 25.86 and a standard deviation of 5.30. The mean years resided in the U.S. is 13.73, with a standard deviation of 10.56. Scores from the Asian American Values Scale – Multidimensional (AAVS-M, Kim, Li, & Ng, 2005) indicated that our participants in general had a medium level of adherence to Asian cultural values (M= 3.93, SD = .64), with mean subscales scores ranging from 3.30 (AAVS-Emotional Control) to 4.33 (AAVS-Achievement). This level of adherence to

Asian cultural values was consistent with results of previous studies (e.g. Li & Kim, 2004 reported AVS $M = 4.18$ and $SD = 0.69$; Kim, Ng, & Ahn, 2005 reported AVS $M = 4.18$ and $SD = 0.65$; Kim, Ng, & Ahn, 2009 reported AVS $M = 3.97$ and $SD = 0.77$), indicating that our participants had a similar level of adherence to Asian cultural values as those in previous similar studies. Lastly, scores from the Counselor Effectiveness Rating Scale (CERS, Atkinson & Carskaddon, 1975) indicated that our participants in general had a slight preference for Western-style counseling (CERS-Western $M = 4.50$) as compared to Asian-style counseling (CERS-Asian $M = 4.42$); however t test conducted later indicated that the observed difference was not significant, $t(195) = -1.01$, $p = .32$. In other words, our participants liked the Asian-style counseling as much as they did the Western-style counseling.

Chi-squares and correlations

Given the multiple demographic variables (i.e. age, gender, years resided in the U.S., whether born in the USA, immigration status, and East Asian vs. Non-East Asian) that may potentially covary with the independent variable (i.e. adherence to Asian cultural values) and dependent variables (i.e. CERS-Asian, CERS-Western, CERS-Difference), several correlations and chi-square analyses were conducted to examine the relationship between these demographic variables, the independent variable, and dependent variables. In other words, we were interested in identifying any secondary variables (i.e. covariates) that can affect the relationship between the independent variable (i.e. adherence to Asian cultural values) and dependent variables (i.e. perceived counselor effectiveness).

Results indicated that age was not significantly correlated with adherence to Asian cultural values ($r = -.04$, $p = .59$). Similarly, results revealed that "years resided in the U.S." was

not significantly correlated with adherence to Asian cultural values (r = .03, p = .72). In other words, age and "years resided in the U.S." did not covariate with the independent variable.

Results indicated that age was not significantly correlated with CERS-Asian (r = -.08, p = .29), CERS-Western (r = -.02, p = .78), and CERS-Difference (r = -.06, p = .40). Similarly, results revealed that "years resided in the U.S." was not significantly correlated with CERS-Asian (r = .07, p = .35), CERS-Western (r = .07, p = .33), and CERS-Difference (r = -.002, p = .97). In other words, age and "years resided in the U.S." did not correlate with dependent variables.

For dummy-coded variables including gender, whether born in the USA, and immigration status, chi-square analyses were conducted. Results indicated that there was no significant difference between male and female participants in terms of adherence to Asian cultural values (χ^2 = 85.31, df = 92, p = .68). Similarly, no significant difference was found on adherence to Asian cultural values between the following groups: those who were born in the U.S. and those who were born outside of the U.S. (χ^2 = 82.88, df = 92, p = .74); those who identified as "resident alien" and those who identified as "permanent resident/citizen" (χ^2 = 191.71, df = 182, p = .30). In other words, these demographic variables (i.e. gender, whether born in the USA, immigration status) did not covary with the independent variable.

Results also indicated that there was no significant difference on CERS-Asian, CERS-Western, and CERS-Difference between the following groups: male vs. female (χ^2 = 54.03, df = 52, p = .40; χ^2 = 60.28, df = 54, p = .26; χ^2 = 88.26, df = 86, p = .41); those who were born in the U.S. and those who were born outside of the U.S. (CERS-Western: χ^2 = 51.03, df = 54, p = .59; CERS-Difference: χ^2 = 104.27, df = 86, p = .09); those who identified as "resident alien" and those who identified as "permanent resident/citizen" (χ^2 = 120.78, df = 104, p = .13; χ^2 = 112.39,

df = 108, *p* = .37; χ^2 = 193.46, *df* = 172, *p* = .13). The only exception to this was the significant difference on CERS-Asian between those who were born in the U.S. and those who were born outside of the U.S. (χ^2 = 71.75, *df* = 52, *p* = .04). In other words, with one exception, these demographic variables (i.e. gender, whether born in the USA, immigration status) did not correlate with the dependent variables.

In summary, with one exception (CERS-Asian and whether born in the U.S.), no secondary variables (i.e. covariates) were identified that could affect the relationship between the independent variable (i.e. adherence to Asian cultural values) and dependent variables (i.e. perceived counselor effectiveness) of primary interest; thus there was no need for any of these demographic variables to be controlled during the main analyses.

Correlations

After ruling out possible "covariates", next we studied the correlations among the independent, dependent, and demographic variables to get a better idea of how they correlated with each other. Variables examined for correlation included age, years resided in the U.S., CERS-Asian, CERS-Western, CERS-Difference, AAVS-M, AAVS-Collectivism, AAVS-Conformity, AAVS-Emotional Control, AAVS-Achievement, and AAVS-Humility. Correlations among these variables are shown in Table 4 (see below).

As indicated in Table 4, of all the correlations of interest, AAVS-M and CERS-Difference were significantly and positively correlated (*r* = .21, *p* < .01). In other words, participants' levels of adherence to Asian cultural values were significantly and positively correlated with the difference between their ratings of the Asian-styled counselor and Western-styled counselor. In other words, the more strongly one adhered to Asian cultural values, the larger the difference was between one's ratings of the Asian-styled counseling and Western-

styled counseling. Of all the subscales of AAVS-M, Collectivism ($r = .22$, $p < .01$) was significantly and positively correlated with CERS-Difference. In other words, the more someone adhered to the Asian cultural values of collectivism, the larger was the difference between their ratings of the Asian-styled counseling and Western-styled counseling.

Table 4
Correlations among the Independent, Dependent, and Demographic Variables (N = 195)

Variable	1	2	3	4	5	6	7	8	9	10	11
1. Age	___										
2. Years resided in the U.S.	.37***	___									
3. CERS-Asian	-.08	.07	___								
4. CERS-Western	-.02	.07	.58***	___							
5. CERS-Difference	-.06	-.002	.46***	-.45***	___						
6. AAVS-M	-.04	.03	.11	-.08	.21**	___					
7. AAVS-Collectivism	-.01	.19**	.13	-.07	.22**	.66***	___				
8. AAVS-Conformity	.01	-.13	.01	-.06	.08	.63***	.24***	___			
9. AAVS-Emotional Control	-.12	-.11	.02	-.11	.14	.70***	.40***	.35***	___		
10. AAVS-Achievement	-.04	.08	.08	-.03	.13	.80***	.37***	.43***	.32***	___	
11. AAVS-Humility	.07	-.02	.11	-.004	.13	.26***	.15*	-.02	.29***	-.14**	___

Note. High scores on all measures indicate higher amounts of that variable. For all variables, the higher number represents a greater amount of that construct. CERS-Asian = Counselor Effectiveness Rating Scale-Asian Style; CERS-Western = Counselor Effectiveness Rating Scale-Western Style; CERS-Difference = Counselor Effectiveness Rating Scale-Difference Score between Asian and Western Styles (i.e. Asian-styled rating minus Western-styled rating); AAVS-M = Asian American Values Scale-Multidimensional; AAVS-Collectivism = Asian American Values Scale- Collectivism subscale; AAVS- Conformity = Asian American Values Scale- Conformity subscale; AAVS- Emotional Control = Asian American Values Scale- Emotional Control; AAVS- Achievement = Asian American Values Scale- Achievement subscale; AAVS- Humility = Asian American Values Scale- Humility subscale.
*$p < .05$. **$p < .01$. ***$p < .001$. N = 195.

Additionally, CERS-Asian and CERS-Western were significantly and positively correlated ($r = .58$, $p < .001$). Participants' ratings of the Asian-styled counseling were significantly and positively correlated with their ratings of the Western-styled counseling. The higher one rated the Asian-styled counseling, the higher that same person rated the Western-styled counseling. In other words, the generous rater seemed to be generous across the board, while the stringent rater seemed to be stringent across the board.

Finally, most of the subscales of AAVS-M were significantly and positively correlated with each other at the $p < .01$ level. In other words, there was much covariance amongst different subscales of the AAVS-M.

Manipulation check

Before we moved on to our principal analyses, we would like to focus on the manipulation check to verify that our study manipulation worked. As mentioned before, a manipulation check was put in place to assess if participants indeed experienced the two conditions differently based on the five criteria we used to operationalize Asian vs. Western styles (i.e. counselor roles; individual vs. collectivistic approaches; counselor preferred mode of expression; presence vs. absence of direct guidance/suggestion; and presence vs. absence of counselor self-disclosure). In particular, participants were asked to rate the two conditions based on these five criteria, which yielded two rating scores (Manipulation-Asian and Manipulation-Western). A paired samples t-test is used to assess if the mean of the two related observations, Manipulation-Asian ($M = 4.16$, $SD = .95$) and Manipulation-Western ($M = 2.91$, $SD = .88$), differ from one another. Results of the paired sample t-test indicate that the mean of Manipulation-Asian is statistically significantly different from the mean of Manipulation-Western ($t = 12.10$, $df = 194$, $p < .001$). In other words, participants in this study perceived difference between the two

test conditions (i.e. Western-style counseling as more "Western" and Eastern-style counseling as more "Eastern" as defined by the five sets of criteria); the client perception of the manipulation was accomplished. Next, we will move on to the main analyses of our study as outlined in the previous chapters.

Principal Analyses

Scatterplots

As stated in previous sections, given previous research on Asian cultural values and counseling outcomes (e.g. Kim & Atkinson, 2002; Kim, Atkinson, & Umemoto, 2001; Kim, Atkinson, & Yang, 1999; Kim et al., 2003), it was our overall hypothesis that Asian American participants' adherence to Asian cultural values predicted perceived counselor effectiveness based on counseling styles (i.e. Asian or Western styled counseling). Specifically, two hypotheses were proposed:

Hypothesis 1: Adherence to Asian cultural values (AAVS-M score) will be significantly predictive of perceived counselor effectiveness (CERS score) based on counseling styles. 1 (a) Stronger adherence to Asian cultural values will predict higher rating of Asian-style counseling (CERS-Asian); 1(b) weaker adherence to Asian cultural values will predict higher rating of Western-style counseling (CERS-Western).

Hypothesis 2: Adherence to Asian cultural values (AAVS-M) will be significantly predictive of perceived difference in effectiveness between Asian-style counseling and Western-style counseling (CERS-difference score). Stronger adherence to Asian cultural values (AAVS-M) will predict larger difference between ratings for Asian-style counseling and Western-style counseling (CERS-difference score). These hypotheses were previously illustrated in Table 1 (see below for a copy of Table 1).

Table 1

Research Hypotheses

Hypothesis	Independent Variable (IV)	Dependent Variables (DVs)	Notes
1	Adherence to Asian cultural values (Measured by AAVS-M)	Perceived counselor effectiveness (Measured by CERS-Asian and CERS-Western)	(a) Higher AAVS-M will predict higher CERS-Asian; *(b)* Lower AAVS-M will predict higher CERS-Western
2	Adherence to Asian cultural values (Measured by AAVS-M)	Perceived difference between Asian-style counseling and Western-style counseling (Measured by CERS-Difference)	Higher AAVS-M will predict larger CERS-Difference

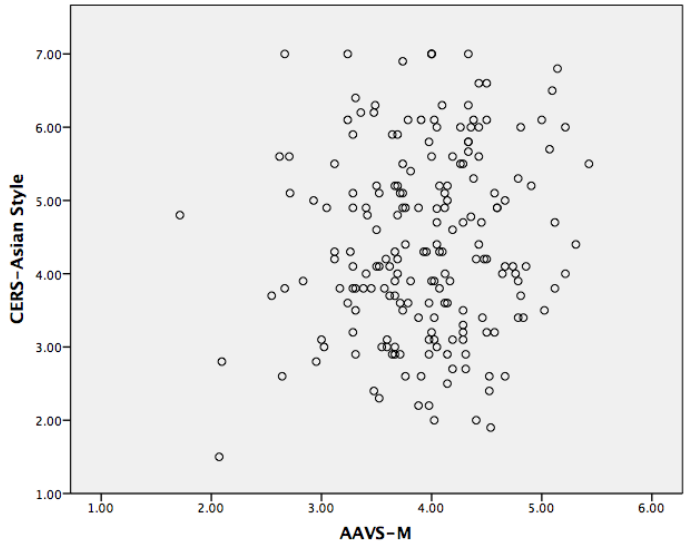
Note. AAVS-M = Asian American Values Scale-Multidimensional; CERS-Asian = Counselor Effectiveness Rating Scale-Asian Style; CERS-Western = Counselor Effectiveness Rating Scale-Western Style; CERS-Difference = Counselor Effectiveness Rating Scale-Difference Score between Asian and Western Styles (i.e. Asian-styled rating minus Western-styled rating).

Given that we have one continuous independent variable (IV, AAVS-M) and one continuous dependent variable (DV) in each proposed analysis (CERS-Asian, CERS-Western, and CERS-Difference), we used three separate simple linear regression analysis to examine the linear relationships between our independent and dependent variables.

In order to graphically illustrate the potential linear relationship between the proposed IV and DVs, three simple scatterplots were used (see graph 1 to 3), each with adherence to Asian cultural values (AAVS-M) as the IV, and one of the following as the DV: (1) perceived counselor effectiveness – Asian style (CERS-Asian); (2) perceived counselor effectiveness - Western style (CERS-Western); and (3) perceived difference score (CERS-Difference).

Graph 1

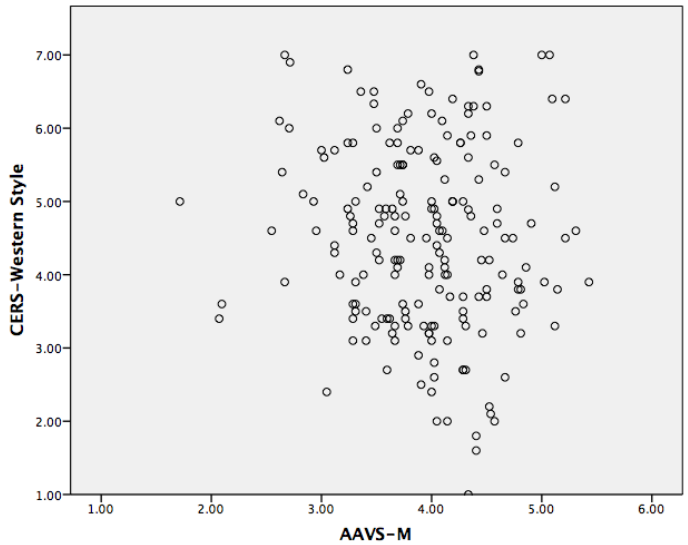
Scatterplot: Relationship between AAVS-M and CERS-Asian



Note. AAVS-M = Asian American Values Scale-Multidimensional; CERS-Asian = Counselor Effectiveness Rating Scale-Asian Style; CERS-Western = Counselor Effectiveness Rating Scale-Western Style; CERS-Difference = Counselor Effectiveness Rating Scale-Difference Score between Asian and Western Styles (i.e. Asian-styled rating minus Western-styled rating).

Graph 2

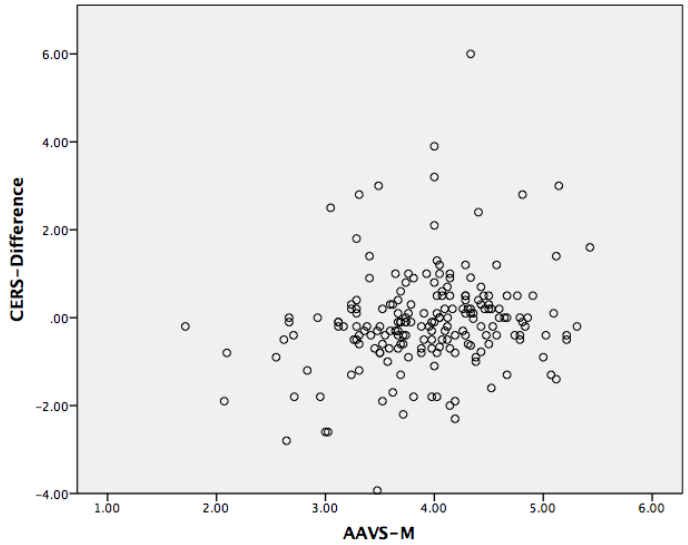
Scatterplot: Relationship between AAVS-M and CERS-Western



Note. AAVS-M = Asian American Values Scale-Multidimensional; CERS-Asian = Counselor Effectiveness Rating Scale-Asian Style; CERS-Western = Counselor Effectiveness Rating Scale-Western Style; CERS-Difference = Counselor Effectiveness Rating Scale-Difference Score between Asian and Western Styles (i.e. Asian-styled rating minus Western-styled rating).

Graph 3

Scatterplot: Relationship between AAVS-M and CERS-Difference



Note. AAVS-M = Asian American Values Scale-Multidimensional; CERS-Asian = Counselor Effectiveness Rating Scale-Asian Style; CERS-Western = Counselor Effectiveness Rating Scale-Western Style; CERS-Difference = Counselor Effectiveness Rating Scale-Difference Score between Asian and Western Styles (i.e. Asian-styled rating minus Western-styled rating).

A linear relationship between adherence to Asian cultural values (AAVS-M) and perceived difference score (CERS-Difference) may be detected in graph 3, as the dots on the scatterplot were arranged in a vertical linear fashion. However, such linear relationship was less obvious in graph 1 and graph 2. In other words, by visually examining the scatterplots, we suspected that there was a linear relationship between adherence to Asian cultural values (AAVS-M) and perceived difference score (CERS-Difference). In the next paragraphs, we will use simple linear regression to statistically determine the relationship between these two variables.

Simple Linear Regressions

Based on the results from the scatterplots, three simple linear regressions were run in order to statistically examine the relationship between the proposed IV and DVs (See Table 5). Again, simple linear regression analysis was used here because it was one of the statistical

analyses that allowed us to examine the linear relationship between our continuous IV (AAVS-M) and continuous DVs (CERS-Asian; CERS-Western; CERS-Difference).

Table 5
Three simple linear regression analyses

Analysis	Independent Variable (IV)	Dependent Variable (DV)
1 (a)	AAVS-M	CERS-Asian
1 (b)	AAVS-M	CERS-Western
2	AAVS-M	CERS-Difference

Note. AAVS-M = Asian American Values Scale-Multidimensional; CERS-Asian = Counselor Effectiveness Rating Scale-Asian Style; CERS-Western = Counselor Effectiveness Rating Scale-Western Style; CERS-Difference = Counselor Effectiveness Rating Scale-Difference Score between Asian and Western Styles (i.e. Asian-styled rating minus Western-styled rating).

Analysis 1(a): Results of simple linear regression indicated no statistically significant linear relationship between adherence to Asian cultural values (AAVS-M) and perceived counselor effectiveness for the Asian-style counseling (CERS-Asian style). The regression model predicted only 1% of the variance, therefore it was not a good fit for the data. In other words, stronger adherence to Asian cultural values did not predict higher rating of Asian-style counseling. See table 6 for details.

Table 6
Summary of Simple Linear Regression Analysis Predicting Counselor Effectiveness (Asian-style) with Asian American Values Adherence (N = 195)

	B	*SE B*	*β*	*t*	*p*
Constant	3.57	.56		6.32	.00
AAVS-M	.22	.14	.11	1.53	.13
	R^2			.01	
	F			2.33	

Note. AAVS-M = Asian American Values Scale-Multidimensional; CERS-Asian = Counselor Effectiveness Rating Scale-Asian Style.
*$p < .05$. **$p < .01$. ***$p < .001$. N = 195.

Analysis 1 (b): Similarly, no statistically significant linear relationship was found between adherence to Asian cultural values (AAVS-M) and perceived counselor effectiveness for the Western-style counseling (CERS-Western). The regression model only predicted 0.7% of

the variance, therefore it was not a good fit for the data. In other words, weaker adherence to Asian cultural values did not predict higher rating of Western-style counseling in our sample. See table 7 for details.

Table 7
Summary of Simple Linear Regression Analysis Predicting Counselor Effectiveness (Western-style) with Asian American Values Adherence (N = 195)

	B	*SE B*	*β*	*t*	*p*
Constant	5.13	.56		9.13	.00
AAVS-M	-.16	.14	-.08	-1.14	.26
	R^2			.007	
	F			1.29	

Note. AAVS-M = Asian American Values Scale-Multidimensional; CERS-Western = Counselor Effectiveness Rating Scale-Western Style.
*p < .05. **p < .01. ***p < .001. N = 195.

Given that hypothesis 1 stated that stronger adherence to Asian cultural values will predict higher rating of Asian-style counseling while weaker adherence to Asian cultural values will predict higher rating of Western-style counseling, hypothesis 1 was not supported in our sample.

Analysis 2: Finally, results of simple linear regression indicated a small but statistically significant positive linear relationship between adherence to Asian cultural values (AAVS-M) and perceived difference between Asian and Eastern styled counseling (CERS-Difference). The regression model predicted 4% of the variance. Stronger adherence to Asian cultural values predicted larger difference between ratings for Asian-style counseling and Western-style counseling. In other words, hypothesis 2 was supported in our sample. See Table 8 for details.

Table 8

Summary of Simple Linear Regression Analysis Predicting Counselor Effectiveness (difference score) with Asian American Values Adherence (N = 195)

	B	*SE B*	*β*	*t*	*p*
Constant	-1.56	.51		-3.09	.002
AAVS-M	.38	.13	.21*	2.96	.003
	R^2			.04	
	F			8.77**	

Note. CERS-Difference = Counselor Effectiveness Rating Scale-Difference Score between Asian and Western Styles (i.e. Asian-styled rating minus Western-styled rating); AAVS-M = Asian American Values Scale-Multidimensional.
*$p < .05$. **$p < .01$. ***$p < .001$. N = 195.

In summary, simple linear regression analyses indicated that stronger adherence to Asian cultural values (AAVS-M) did not predict higher rating of Asian-style counseling (CERS-Asian); nor did weaker adherence to Asian cultural values predicted higher rating of Western-style counseling (CERS-Western) in our sample. However, stronger adherence to Asian cultural values (AAVS-M) did predict larger difference between ratings for Asian-style counseling and Western-style counseling (CERS-difference score). In other words, hypothesis 1 was NOT supported in our sample, while hypothesis 2 was supported.

CHAPTER V

DISCUSSION

Kim, Atkinson, and Umemoto (2001) proposed that the therapy process is enhanced when the client's cultural values are consistent with values embedded in counseling. Based on this theoretical proposal, a series of empirical studies were conducted to examine the effects of Asian American participants' adherence to Asian cultural values on counseling outcomes, including perceived counselor effectiveness (e.g. Kim & Atkinson, 2002; Kim, Atkinson, & Umemoto, 2001; Kim et al., 2003). Thus far, empirical studies have yielded inconsistent results in terms of the effect of client adherence to Asian cultural values on perceived counselor effectiveness. In addition, these studies tended to focus on identifying individual therapy factors that differentiated Asian vs. Western styles of counseling (i.e. directive vs. indirective styles, self-disclosure or no self-disclosure, emotion-focus or cognition-focus, etc.) without much synthesizing. Finally, it was unclear whether the effect of client adherence to Asian cultural values on perceived counselor effectiveness was a function of counselor ethnicity (i.e. Asian American counselor vs. European American counselor) or counseling style (i.e. Asian-style counseling vs. Western-style counseling).

The present study used an audiovisual analogue design to evaluate whether participants' adherence to Asian cultural values predicts their perceived counselor effectiveness of an Asian American counselor, based on counseling styles (Asian vs. Western style). Five sets of contrasting features were identified from the literature that differentiated Asian-style vs. Western-style counseling, including: (1) counselor roles (facilitator vs. expert); (2) individualistic vs. collectivistic approaches (i.e. focus on individual vs. focus on context/family dynamics); (3) counselor preferred mode of expression (verbal vs. non-verbal; or low context vs.

high context communication); (4) avoidance of direct guidance/suggestion vs. direct guidance/suggestion; (5) avoidance of counselor self-disclosure vs. counselor self-disclosure of strategies used in the past. We hypothesized that: 1(a) stronger adherence to Asian cultural values will predict higher rating of Asian-style counseling; 1(b) weaker adherence to Asian cultural values will predict higher rating of Western-style counseling; and (2) stronger adherence to Asian cultural values will predict larger difference between ratings for Asian-style counseling and Western-style counseling. While our first hypothesis was an effort to confirm or disconfirm the mixed results in the literature regarding the relationship between adherence to Asian cultural values and perceived counselor effectiveness, our second hypothesis was entirely new to the literature. Specifically, we exposed our participants to both Asian-style and Western-style counseling, thus providing the precious opportunity for us to empirically examine participants' style preferences and sensitivity to style difference. We suspected that higher adherence to Asian cultural values will predict higher sensitivity to style difference, resulting in a larger difference score between ratings for Asian-style counseling and Western-style counseling.

Results from the present study failed to support the first hypothesis, which states that stronger adherence to Asian cultural values will predict higher rating of Asian-style counseling. In fact, participants rated the Asian American counselor as equally effective when she employed Asian-style counseling and Western-style counseling. The lack of a significant effect of participants' adherence to Asian cultural values on perceived counselor effectiveness based on counseling styles was not unexpected given inconsistent results from past research based on one-session volunteer client study. Adherence to Asian cultural values were found to be positively predictive of participants' rating of Asian American counselors' levels of empathy and credibility (Kim & Atkinson, 2002) as well as European American female counselors' levels of

empathy and working alliance (Kim, Li, & Liang, 2002). However, Kim et al. (2003) and Li & Kim (2004) found no relationships between Asian American clients' adherence to Asian cultural values and counseling outcomes with European American counselor. In other words, empirical studies based on one-session volunteer client study have yielded inconsistent results; our study based on video vignette of a mock session of an Asian American dyad was not able to provide empirical support to Kim, Atkinson, and Umemoto (2001)'s proposition either.

How do we understand the lack of significant relationship between client adherence to Asian cultural values and perceived counselor effectiveness in our study? We know that participants in our study did perceive the two styles as different, based on our manipulation check. In other words, participants were able to detect the nuanced style differences between Asian-style counseling and Western-style counseling based on the five dimensions identified from literature. However they perceived the female Asian counselor who practiced these two styles of counseling as equally effective, attractive, trustworthy, and useful.

One possible way to understand this result could be that the counselor's apparent ethnicity (i.e. being Asian American) trumped the style difference (i.e. Asian-style vs. Western-style counseling). Perhaps the presence of an Asian American counselor was more salient for participants than the specific style of counseling she practiced in each vignette. Alternatively, we could speculate that common therapeutic factors (e.g. empathy, rapport, verbal and non-verbal attending behaviors) trumped the style difference (i.e. Asian-style vs. Western-style counseling). Perhaps the presence of apparent therapeutic alliance and empathy in each vignette was enough for participants to believe that the counselor was competent and trustworthy, despite the specific style of counseling she practiced. Lastly, participants might have liked the female Asian American counselor in each scenario in different ways (e.g. participants might have liked the

authoritative Asian counselor for her apparent expertise and the facilitative Western counselor for her authenticity and genuineness), however they were both considered "helpful" in their own ways. In any case, as counter-intuitive as it might seem, it was refreshing for us as researcher and clinician to know that both Asian and Western styles of counseling were appreciated and valued by our Asian American participants. It also seems important to continue this line of research to better understand the mixed empirical results in extant literature.

Additionally, results from simple linear regression analyses supported our second hypothesis that participants with higher adherence to Asian cultural values perceived a larger difference between their perceptions of Asian-style and Western-style counselor, as compared to participants with lower adherence to Asian cultural values. While stronger adherence to Asian cultural values did not predict higher rating of Asian-style counseling, it did predict enhanced sensitivity to style differences for participants in our study, with a preference for Asian-style counseling. .

How do we understand this enhanced sensitivity to style difference and preference for Asian-style counseling within our high adherence group? Recall that our outcome measure, the CERS (Atkinson & Carskaddon, 1975), is a global measure of perceived counselor credibility based on four dimensions (i.e., expertness, attractiveness, trustworthiness, and utility). Within the scope of a 5-minute simulated career counseling session, we can speculated that the Asian-style counselor who was intentionally acting as an authority figure, giving direct guidance/suggestion, and making self-disclosure of past strategies used, might be perceived as more willing, effective, and "expert-like" for people who adheres to strongly to Asian culture value, where "help" is often conceptualized as the imparting of knowledge and wisdom. However, when these clients encounter the Western-style counselor who acted as a "facilitator," who intentionally avoided

direct guidance/suggestion and self-disclosure of effective strategies in the past, they may perceive the counselor as withholding, cold, unhelpful, and ineffective. In other words, we are speculating a larger "expectation gap" or "cultural gap" between what was conceptualized as "help" by the high adherence group and what was offered as "help" by Western-style counselor.

Implications for theory

The results of our first hypothesis challenged Kim, Atkinson, and Umemoto's theoretical proposition (2001) that culture consistency between client values and therapy values facilitates therapy, whereas cultural conflict between client values and therapy values impedes therapy. On the contrary, our results indicated that Asian American participants were able to appreciate the effectiveness of both styles, despite their levels of adherence to Asian cultural values. In other words, we found no evidence to support a linear relationship between Asian American participants' cultural adherence and the perceived effectiveness of Asian American counselor.

This apparent contradiction between theoretical propositions put forth by Kim, Atkinson, and Umemoto (2001) and results of our empirical study led us to ponder this theory in more depth. Could cultural conflicts between client values and therapy values lead to positive change? Could cultural homogeneity between client values and therapy values impede growth and learning? Perhaps therapy is more dynamic than the hypothesized linear process, where clients are more adaptive than described in these theoretical propositions. Instead of viewing clients as passive recipients whose therapy process is invariably hindered when culture values clash in the therapy room, we might conceptualize clients as active participants in the therapy process who continuously adapt and selectively benefit from therapeutic interventions. Perhaps the difference between cultural values held by clients and cultural values inherent in counseling could be both a

source of conflict and a place of growth. In fact, it is not uncommon for clinicians to encounter clients who purposefully seek out therapists from culture backgrounds that are vastly different from their own for various reasons.

While stronger adherence to Asian cultural values did not predict higher rating of Asian-style counseling, it did predict enhanced sensitivity to style differences for participants in our study, with a preference for Asian-style counseling. Based on these results, it seems reasonable to speculate that cultural inconsistency may lead to heightened sensitivity to style difference, which do not necessarily translate into enhanced or impeded therapeutic process. In other words, we may speculate that for someone who adheres strongly to Asian cultural values, they may quickly notice the difference between Asian-style counseling and Western-style counseling, both of which could potentially be beneficial and effective for them.

In any case, a more nuanced theory regarding the relationship between cultural values and therapy outcome seems to be necessary to account for evidence emerging from empirical studies.

Implications for future research

The present study offers a number of directions for future research. First, our study is the first attempt we are aware of to operationalize "Asian-style counseling" and "Western-style counseling" by eliciting from literature five contrasting features that differentiate Asian and Western styles of counseling. Whereas previous studies generally used counselor ethnicity as a proxy for counseling style, ours is the first study to operationalize different styles by identifying criteria and actualizing them in pre-recorded video session. Our operationalization of "Asian-style counseling" and "Western-style counseling" was successful in that participants were able to appreciate the style difference. Future studies can continue to identify other factors that

differentiate Asian-style vs. Western-style counseling, operationalize them, and test them empirically. The challenge though, is to decide which therapeutic interventions/stance are "Asian" and which are "Western," especially in a world where both traditions are actively learning from each other.

Additionally, it would be interesting to manipulate other variables in the study to examine different therapeutic factors. For example, it may be relevant to employ a non-Asian counselor to examine if non-Asian counselors can employ the "Asian-style counseling". In a world of psychology internationalization and indigenization, it is not unusual for Western counselors to actively and selectively apply therapeutic interventions that are often considered "Asian" (e.g. possessing a more authoritative stance with clients who are looking for an authority; intentional use of self-disclosure). Alternatively, many Asian counselors are trained in Western traditions or Western institutions nowadays, and it might be interesting to see how these Western-trained Asian counselors are perceived by Asian clients with varying degrees of adherence to their heritage culture. Given our hypothesis that therapist ethnicity might have overridden the nuanced differences in counseling styles (p.66), it would be interesting to utilize a 2X2X2 design (High/Low Adherence X White/Asian American Counselor X Asian-style/Western-style counseling) in future studies to analyze the proposed effect of apparent counselor ethnicity. In any case, there seems to be a multitude of interesting combinations we could employ and empirically examine with our methodology. Similarly, it may be interesting to employ a male counselor as compared to a female counselor to examine how gender plays a role in the relationship between cultural values and counseling outcomes.

Finally, given the interesting results we found by comparing Asian-style counseling and Western-style counseling, it seems important to continue to investigate the difference between

perceived effectiveness of these two styles of counseling. Perhaps a new variable, such as "style sensitivity" or "style preference" could be created to formally address the difference between ratings of Asian-style counseling and Western-style counseling.

Implication for practice and training

The present study has implications for practice with Asian American clients. Our results indicated that clients with varying degrees of adherence to Asian cultural values could benefit from both Asian-style and Western-style counseling. This is quite liberating in that therapists may not have to adhere dogmatically and inflexible to cultural prescriptions when they work with Asian American clients. Rather, therapists are encouraged to view clients as having the potential to benefit from a host of interventions, and engage them in finding out the individualized approach that fits their needs.

Additionally, based on results from Hypothesis 2, participants who had higher adherence to Asian cultural values were more sensitive to style differences, with a preference for Asian-styled counseling. It seems important for therapists to be aware of this increased sensitivity for those who have higher level of adherence to their Asian heritage and allow space in the therapeutic process for their Asian American clients to communicate how culture impacts their therapy process. One way of assessing client's adherence to their heritage culture could be asking directly in the intake paperwork their cultural identification as well as the level to which they identify with their heritage culture (e.g. "How much do you identify with your heritage culture?" "Not at all", "A little bit," "Quite a bit"). In the future, it may be beneficial to assess clients' adherence to their heritage culture in a more systematic fashion by implementing measures similar to AAVS-M (Kim, Li, & Ng, 2005).

In terms of training, it seems important to inform future clinicians of the impact of client

adherence to Asian cultural values on perceived counselor effectiveness, in terms of style sensitivity and style preference. Given the mixed results in the field, it seems important to train our future clinicians to be alert to both traditional Western-style counseling as well as Asian style counseling, and learn the skills needed to tailor therapeutic interventions and stance based on individual client. The lesson learned in our study seems to be that therapists need to remain open-minded to different counseling styles based on the needs of their client. While we do not advise therapists to use an authoritative, suggestion-giving, and self-disclosing style with ALL of their Asian clients, we do encourage therapist to assess their Asian client's adherence to Asian cultural values (e.g. "How much do you think you identify with your heritage culture?" "How important are these values for you?") as well as their expectation for what constitute as "help" (e.g. "What do you expect in therapy?" "What would be most helpful to you?"). We encourage therapists to gain an in-depth understanding of client's individual experience of their culture, including what their culture means to them and what elements of their culture that they actual identity with. In other words, instead of utilizing an one-size-fits-all intervention, we encourage counselors to engage their Asian clients in an on-going dialogue in what is most helpful and effective for them; and if what they ask for is direct guidance and suggestion, don't shy away from these potent interventions just because traditional Western therapy forbid their use.

Limitations

Finally, there are several limitations to our study. First of all, given the research design of our study, our conclusion is limited in its generalizability. Specifically, our results are based on a one-session video analogue study. Therefore, we are essentially inferring the client's reactions and experiences by showing session vignettes to study participants. However, we are well aware that study participants, who are essentially observers of the therapy session, are not clients. And

their reactions are essentially second-hand. In the future, it may be beneficial to conduct intervention analogue study (e.g. one-session intervention study with actual clients) to make the study results more generalizable.

Second, we utilized a career counseling session in our study design. Although career counseling is one form of counseling, its process could be quite different from personal counseling, and there might be more needs from the client for guidance and direction. On the other hand, utilizing a personal counseling session might have brought up more emotional content and potentially illuminated client's different responses to different counseling styles. Therefore, our results are more specific to career counseling process. In the future, it may be interesting to utilize a personal counseling session to expand the applicability of our study. Additionally, we presented two vignettes to all participants in the same order (Asian-style first, Western-style second), therefore raising concerns for the order effect. In the future, it would be advised for researchers to counterbalance vignettes so that participants are exposed to different vignettes in random order.

Last but not the least, we recognize that our sample is somewhat biased in terms of being a rather young, college-educated, highly acculturated, English proficient, and Internet literate sample. Specifically, administering interventions in English may have skewed our sample, in that potential participants may have been discouraged from taking the survey if they were not proficient in English. As a result of this biased sample, there was limited variance in our participants' levels of adherence to Asian cultural values. Specifically, the mean score and standard deviation of the AAVS-M score were 3.97 and .68, which presented less than one standard deviation of variance within the sample. Similarly, an analysis of Graph 1-3 on page 58 to 59 revealed that AAVS-M scores were clustered on the X-axis, indicating a lack of variance in

terms of participants' adherence to Asian Cultural Values. Therefore, it is important to note that when we refer to "high" and "low" adherence to Asian cultural values in this sample, we are referring to the "high" and "low" within a highly acculturated sample. In the future, it may be interesting to examine a more diverse Asian sample, such as recent immigrants and clinical population, which hopefully will present more variance in terms of client adherence to Asian cultural values. In other words, we might expect different effects of the two styles of counseling with a different group of Asian Americans.

In conclusion, based on literature from both North American multicultural counseling research as well as indigenous counseling research in Asia, especially Kim, Atkinson, and Umemoto's (2001) proposal that the therapy process is enhanced when the client's cultural values are consistent with values embedded in counseling, we conducted an empirical study to examine the effects of Asian American participants' adherence to Asian cultural values on perceived counselor effectiveness based on two styles of counseling (i.e. Asian-style counseling and Western-style counseling). We identified five sets of contrasting features from the literature that differentiated Asian-style vs. Western-style counseling, including counselor role, counselor approach, counselor preferred mode of expression, presence or absence of direct guidance, and presence or absence of self-disclosure. We hypothesized that: 1(a) stronger adherence to Asian cultural values will predict higher rating of Asian-style counseling; 1(b) weaker adherence to Asian cultural values will predict higher rating of Western-style counseling; and (2) stronger adherence to Asian cultural values will predict larger difference between ratings for Asian-style counseling and Western-style counseling. Results from our study failed to support the first hypothesis, which states that stronger adherence to Asian cultural values will predict higher

rating of Asian-style counseling. However, our results indicated that those who had higher adherence to Asian cultural values were more sensitive to style differences, with a preference for Asian-styled counseling. As such, we urge scientists to continue the empirical investigation on this issue, and clinicians to be more attentive to Asian American clients' level of adherence to their heritage culture and allow room for cultural communications. We recognize that our sample is biased in terms of being a rather young, college-educated, highly acculturated, English proficient, and Internet literate sample, and therefore our results are limited in terms of its generalizability to the general Asian American population. We made the suggestion that therapists remain open-minded to different counseling styles and engage Asian clients in an on-going dialogue in what is most helpful and effective for them in their individual setting.

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APPENDIX
VIDEO SCRIPTS

Three-stage session process

(1) Eastern-style

Stage 1: Identification of the problem

(Counselor introducing herself and asking client to state briefly her reason for seeking services; Client will talk about his recent struggles with career concerns (e.g. trying to choose between pre-med or music majors as a first generation Asian American; worrying about career choices and future prospects);

Dr. Lin: Hi David. My name is Dr. Lin and I'm going to be your therapist here at the Counseling Center. Can you tell me a little bit about what brought you in today?

David: Sure. Well, recently I've been struggling with my future career. You see, I'm a sophomore now and I need to declare a major as soon as possible. So far I've been really interested in music and I've taken lots of music-related classes, like piano, music history, and composition; however, I'm not sure I'll declare music as my major.

Dr. Lin: hmm, can you say a bit more about that?

David: yeah…you see, my parents are originally from China, and they came to the U.S. in their 20th. They've worked really hard in the family restaurant trying to support me through college, and even though they told me that I should study whatever I'm truly interested in, I know they would probably like me to choose something more pragmatic, something like pre-med or engineering. Plus, I'm not quite sure myself that music is a financially viable career; there are so many talented musicians out there.

Stage 2: Brainstorming possible solutions

(Counselor and client will process possible solutions for the presenting problem; counselor will providing direct guidance/suggestion as well as engage in self-disclosure of strategies used in the past with similar problems; counselor will also utilize a collectivistic approach where family dynamics and family needs were addressed, in addition to individual needs)

Dr. Lin: I see. It sounds like you've been struggling with declaring a major. While you're interested in music, you're also aware of your parents' unspoken expectations for you to choose something more "pragmatic." It seems that you are very aware of how your parents have been supporting you, and you are concerned about their wishes and needs (collectivistic approach). Does that sound about right?

David: Yeah. Exactly. I really don't know what to do now. Do you have any suggestions?

Dr. Lin: Well, I can share with you what I did in the past with similar problems. But first I would like the two of us to work together to see if we can come up with some possible solutions (brainstorm solutions). What are some ideas do you have?

David: Well, to start with, maybe I could find out what I really like to do. I need some more clarification as to what is it that I want to do.

Dr. Lin: Good. And to do that, we have some career testing batteries here at the center that can facilitate you in that process, such as the Strong Inventory and MBTI. Have you heard of these career testing measures (direct guidance/suggestion)?
David: I've heard of MBTI.
Dr. Lin: Good. I remember when I was a freshman in college, I had quite similar concerns, and I took these tests myself. They were very eye-opening for me and helped me understood what was it that I really wanted to do (self-disclosure).
David. That sounds great. I would like to do them too.
Dr. Lin: Sure. We can arrange that. What other solutions do you have in mind?
David: Well, I guess I can always talk to my friends and even my parents about it. I want to get some support from my friends, and I would like to know what my parents are really thinking on this issue.
Dr. Lin: Sounds like a good idea. Anything else?
David: I could probably talk to professors in both music and pre-med programs. Perhaps they'll also have some insights to my dilemma.
Dr. Lin: That's right. Sounds like you really have a number of options in helping yourself sort the situation out.
David: Yeah, I guess. I was so buried in my own thoughts that I sort of ignored the resources I have.
Dr. Lin: Yeah, it does sound like you have very supportive parents. I wonder how your relationship is with them?
David: I'm pretty close with my mom; my Dad and I don't talk that much, but I know he loves me. You know the joke, in Asia families, parents don't say "I love you," they say "Are you hungry?" That's my family.

Stage 3: Summary of treatment process
(counselor will summarize what happened in this session and ended with encouragement for

client's willingness to work on his issues.)

Dr. Lin: Hmm, that sounds about right. Anyways, I'm glad we had a chance for you to brainstorm some solutions to your current dilemma. I'm also impressed by how open and willing you are to work on this issue and talk about it. It's about time for our session today. Let's continue our discussion same time next week?
David: Sure. Thank you, Dr. Lin!
Dr. Lin: You're welcome. Goodbye.
David: Bye.

(2) Western-style
Stage 1: Identification of the problem
Same as "Eastern-style."

Stage 2: Processing underlining issues

(Client will be asked to explore of underlying issues of her presenting problem; counselor will encourage client to verbally express his or her feelings (e.g. how do you *feel* about this) and thoughts (e.g. how do you *think* about this); Counselor will maintain a facilitator role by refraining from giving solutions/suggestion/self-disclosure; instead counselor will encourage client to explore her own issues and come up with her own understandings; session will be strictly focused on client's individual needs, while processing of family needs are discouraged.)

Dr. Lin: I see. It sounds like you've been struggling with declaring a major. While you're interested in music, you're also aware of your parents' unspoken expectations for you to study something more "pragmatic." Plus, you are not quite sure yourself whether this is a financial viable career. Does that sound about right?

David: Yeah. Exactly. I really don't know what to do now. Do you have any suggestions?

Dr. Lin: Well, before we jump to any suggestions or solutions, let's first spend some time processing your own thoughts and feelings about it. How do YOU feel about this dilemma?

David: I'm not sure…I've always thought of myself as an optimistic person. However recently I'm feeling really torn about this issue. I haven't been sleeping or eating well.

Dr. Lin: Hmm, can you say more about feeling "torn"?

David: I don't know…on one hand, I really like music and I think I've got something to share with the world. On the other hand, I'm the only boy in the family (I've got an older sister), and I feel somewhat "selfish" to pursue a career that's financially shaky.

Dr. Lin: "Selfish?"

David: Yeah…I guess ideally I would like to help financially contribute to my family after graduation. I'm a man and I feel old enough to take on some responsibilities. I wish I don't have this passion for music, that way I'll just pursue some "traditional" career for Asian Americans, such as engineering or medicine.

Dr. Lin: Hmm…you said a lot. I'm curious about what is it that you want, aside from your family's need?

David: Well, I want to be happy. I want to do something I feel passionate about.

Dr. Lin: Hmm…how do you think you can get to that place?

David: By doing what is it that I genuinely like to do, I guess. I'm stuck between feeling "happy" in a selfish way and feeling "miserable" but morally responsible.

Dr. Lin: That's very insightful.

David: Thank you, Dr. Lin, I never thought about all these issues before I came here.

Stage 3: Summary of treatment process

Same as "Eastern-style." (except for "Anyways, I'm glad we had a chance for you to process your thoughts and feelings as related to your current dilemma.")